			1 - For State Registrer	State of N	/larylan		artmen rtificate			and Me	ental Hy	giene Reg. No.		00001
	Physici /Medio		1. Decedent's Name (First, Middle, La HORRIET	st)		PEI	158	=1<	•		2. Date of De Month	eath Day		3. Time of Death  2:02AM
1	Examin		4a. Facility Name (If not institution, giv Gilchrist Hospic		r)		4b. City,		Location o	of Death			County of Dea	
	Funeral Director		5. Social Security Number 6. S		nge (In yrs. <b>74</b>	last birthday) Yrs.	If Under Months		ff Under: Hours		8. Date of Bir (Month, D) 01/16/	rth	9. Bi	thplace (State or Foreign ountry) 'Yland
	Maryland f show ied al	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimor	e	1	timore								10d. fnside City Limits 1 ☐ Yes 2 🖔 No
	with the a or 28a Lbe notil	Director	10e. Street and Number 2410 Mayfield Av		1. =		10f. Zip					10g. Citi	zen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelith and Mental Hygiene. Important: if tiem 27 is marked other then "natural", or iteme 23a or 28a-f show important: if tiem 27 is marked other then "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, if a Medical Exartifiat must be notified at once.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? <b>(</b> No	1		lent of His	spanic Orig n, Mexican Specify:	gin? (Spec n, Puerto R	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify: W	te, etc.
21215-0036	within 72 houiene. I then "nature I e Medical	Completed	15. Decedent's En (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed)  College (1-40)	r 5+)	16a. Deced (Give life.	kind of wor DO NOT us	rk doné d	urina most	t of workin	g		nd of Business	/Industry
Maryland 2	2 should be filed and Mental Hygi Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last, Charles Armiger	· · · · · · · · · · · · · · · · · · ·				-	Mabl	le To		, Maiden	Sumame)	
	and 2 sh leelth and m 27 is n		19a. Informant's Name/Relationship ( Susan Kolberg, D			131 B	ourbo	n Ct			Route Numb		r Town, State, 234	Zip Code)
altimore,	Pages 1 ment of H ant: if iter lury or oth		20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		e Hil	Place of Dispo cemetery, crer LITOP S	sition (Nan natory or or OCTVIC	ne of ther place CC	orp. (	<sup>Da</sup> 08/14	·/2006	Tow	son, Ma	
Ball	permit. Pag Department Important: it eny injury o		21. Signature of Funeral Service Licer	Bates		5	305 H	arfo	rd Ro	oad, I	Baltim	ore,	ck, Inc MD 212	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	offications that cause one cause on each a. SGUM	ed the deat line. MOUS (	h. Do not ent	_				respiratory a	_	MARY	Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions	Due to (or a										0
V	cate be executed physicien and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or a										
68/60	8 분	dicai		d										
O. Box	at the death certifi by the ettending   teched for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≥ No 9 □ Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 🗌 Feta	I death 3	Ectopic pro Other (spe					2	23d. Date of de Month	livery Day Year
rds, P	signed d be de	۵	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.			obacco u Yes 2[	_	o the cause of death?
al Kecord	The ete h page	Completed								·	24a. Was auto perio 1 🗆 Yes		death?	utopsy findings available completion of cause of
or Vital	Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes  No	Hospital: 1 ☐ Inpat	tient 2	ER/Outpatien	t 3 🗆 DO	Othe	r		(Check only o e 5□Resi		Other (Spe	cirtospice
JIVISION	After fune	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		jury ay Year)	28b. Time of Injury	M 2	8c. Injury Work' 1 🗌 Y	at ? ′es 2 □ N		8d. Describe	how injur	y occurred	
	e Hospital or Atten 24 hours after deat e Funaral Director: letely filled in by the		3 Suicide 6 Could not be determined	building, e	etc. (Specify	y)					City or To	wn, State,	)	ural Route Number,
	44 T 99	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	of examina	wledge, death tion and/or inv	occurred a restigation,	in my opi	e, date and inion, deat	d place, ar th occurred	nd due to the d at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the To the compl	Σ	29b. Signature and title of certifier	RF	1006		29c	. License	number	42		29d. Date	signed (Moni	th, Day, Year)
	5			completed cause of	death (Item		Print) Chau	les	~~ (+~	/	Px 0+	~ ^	77 3.	204
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signa		book	,	5140	-1/_	un!	<u> </u>	<i>U</i>	00 1

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** MUGUST°ª'8. 2006 5:28P Edward Roddy Francis /Medical 4b. City, Town, or Location of Death 4a. Eacility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death.
Baltimore Examiner Date of Birth (Month, Day, Year) 1917 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 XM 2 ☐ F 9. Birthplace (State or Foreign **Funeral** New York 116-01-7176 89 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits fraumatic avant, the Mudical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 136 Dublin Drive 21093 U.S.A. deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. δ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Project Manager U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked other any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Patrick Η. Roddy Vina Legue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Μ. Roddy Son 606 Meadowridge Road Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Mt. Maria Cemetery 8-14-2006 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road au Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** /Medical resulting in death) Due to (or as a consequence of):
IDIOPATHIC FULMONARY FIBROSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sicion and burial-transit The law requires that the death certificate be executed SEPSIS that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical anding physical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be LACTIC ACIDOSIS 2No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I lirector, page 2 s autopsy performe Yes 2 1 ☐ Yes 1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only on 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ Hisatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled tha Hospitel 24 hours a Funeral Physician: To the best of my knowledge death ancursed at the time, date and place and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of -ath (Item 23a) (Type, Print) 7601 OLSER DRIVE TOWSON, MARYLAND 21204 LOW M. D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) 1 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

				State of Maryland / Department of Health and Certificate of Death		giene2 ()	06	25503
		<b>D</b> 1		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	18 <sup>ay</sup> 200	Year	3. Time of Death
	N.	Physicia /Medic		Donald E. Rickert, Sr.	August or Location of Death			5:00 PM
	1	Examin	er	4a. Lability Halife (in hot mountain), give direct and halifest,		4c. County		
				5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 H	rs. 8 Date of Birt	h	9. Birtho	ace (State or Foreign
		Funeral Director		218-03-6661 1XD M 2 F 86 Yrs. Months Days Hours M	lin. (Month, Da Aug. 29	, 1919	Mary	Tand
		P .		Usual Residence of Decedent			1/	Od. Inside City Limits
		shov	ō	MD Baltimore Parkville			"	1 □ Yes 2 No
		28e-f	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	/hat Coun	try?
		3a or	Ē	8820 Walther Blvd. Apt. 3215 21234		USA		
		death	ner	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	14. Race	- Americ	
せ	20	ours after death with the Maryla ral', or items 23a or 28e-f shor Evarriner must be notified at	y Fu	1 ☐ Never Married 2X Married 1X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2X No Specify:			whi	
RICKER	21215-0020	n 72 hours "netural", e edical Exa	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	siness/Inc	lustry
X	215	be filed within 72 ho tal Hygiene. d other then "netur event, tre Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Manage	working er of	Social	Secu	rity
	21;	od with	Com	12 Printing Pro		Admini		ion
X	Maryland	2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. Is marked other then "netural", or frems 23a or 28e-f show reumatic event, the Medical Examiner must be notified at	Be	in the state of th	<sub>Name (First, Middle,</sub> Selle Hass		θ)	
(17	Z	d 2 should be th and Mental 7 is marked of treumatic ev	7	Willis Henry Rickert  Anna B  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			State, Zip	Code)
lΠ	-	D + V + D		Robert J. Rickert / son 2203 Eastridge Road;				
9	Baltimore,	es 1 and 2 of Health item 27 is r other tre		20a. Method of Disposition  11√2√Burial 2 □ Cremation 3 □ Removal from State	Date	20c. Location -	City or To	wn, State
bonald	ij	permit. Pages 1 Department of H Important: if ite any injury or ot once.		4'\(\text{Donation}\) for □Other (Specify) Dulaney Valley Mem Gardens	8/16/06	Timoniu	n, MC	)
િ	Ball	Depart Mport Iny in		21. Signature of Fune all Service Licensee 22. Name and Address of Facility		1050		
A		40 = 0 G		Ruck Towson Funer  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care			n, ME	21204 Approximate
		Physician		shock, or heart failure. List only one cause on each line.	alao or roopiratory a		1	Interval Between Onset and Death
		/Medical		Immediate Cause (Final disease or condition			1	
		Examiner	<u>.</u>	resulting in death)  Due to (or as a consequence of):				
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_ \	بر ا	execu n and iai-tra	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  C.  Due to (or as a consequence of):				
SPH	8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	dicai	Cause (Disease or injury that initiated events presulting in death) Last Due to (or as a consequence of):				
w	9	n certifica ending ph use as t	Med	d d				
	Вох	eath certifi attending   I for use as	sian/		201 201			the server of death?
چ	P.O.	that the de led by the a detached i	Physician/Me	Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.			3 □ Prot	the cause of death?
भक्कर   ०१ वि		es that igned b be deta	by P		_			
6	Records,	v require been sig should t				an autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause
-	Šeč	elawr hasbe ge2sh	Completed				of (	death?
$\mathfrak{w}$	al F	ysician: The last certificate hadirector, page		On Plant of	Death (Check only of	Yas 2 Nu	11.	Yes 2 No
	Vital	Physician: this certific ral director,	o Be	examiner? Hospital:	ng Home 5 ☐ Resi		er (Specif	()
	n of	<u>ਦੇ</u> ਜ਼ੁੰਦ	Ju: T	27. Mann	28d. Describe	how injury occurr	ed	
	siol	tendir leath. tor: Af the fu	catic	2 Accident investigation M 1 Yes 2 No	28f Location (	Street and Numb	er or Rura	l Route Number
	Division	or At efter of Direct in by	Certification:	3 ☐ Suicide 4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To		or or ribra	riodio riambol,
	_	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)  1 ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	lace, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
		To the within To the somple	N N	29c. Liceose number		29d. Data signed	d (Month,	Day, Year)
				120/900000000000000000000000000000000000	45	8/10	0 0	م
		'OX,	١.,	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1111.	2 210	611	
				Bruce Flunchtal 4D 8800 Walther Blvd Park: 31. Date filed (Month, Day, Year) 32. Megistrar's Signature	MIE, M	V 212	154	
	Y	Sta Registr		AUG 1 4 2006 Rome Br Soule				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Scott Robertson AUQU)+ Joshua 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Year If Under 24 Hrs. Saint psata n/a Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**∑** M 2□ F Yrs. 2006 Maryland Director None August Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location or iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Eldersburg Director Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21784 1185 Fetterbush Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be t nent of Health and Mental I int: It item 27 ie marked o Heather Johnston Scott Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) 1185 Fetterbush Circle Eldersburg, Maryland 21784 Mr. Scott Robertson (Father) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Depertment of important: It eny Injury or once. Dulaney Valley Mem. Gdns. 8/10/2006 Maryland Timonium 5 Other (Specify) 4 Donation 21204 permit. 22. Name and Address of Facility 21. Signature Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final xtreme Physician resulting in death) /Medical to (or as a consequence of) Examiner Thoor 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by should be 1 | Yes 2 | No 3 | Probably 4 | Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? 2 No certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physicien: ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) s efter dearn.
ral Director: After this cen-Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural 1 Tes 2 No М 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 0063566

State Registrar 30. Name and address of person who cor Rakhi V. Gupta

AUG 1

31. Date filed (Month, Day, Year)

Hospital, 900 (aton Avenue, Baltimore, Maryland

eted cause of death (Item 23a) (Type, Print)

Saint Agnes

2. Registrar's Signature

MD

4 2006

21229

DHMH 17 Rev 1/2001

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ROUSH, JOSEPH

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Physician 2006 6:30 PM 4ugust /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** hesapeake Medical BelAir Har tor | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Aug. 11, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🖾 F 141-09-5476 1915 New Jersey Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County il Hygiene. other than "natural", or Iteme 23a or 28a-1 show vent, the Madical Examinar must be notified at 1 X Yes 2 □ No Directo Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 502 Hemingway Drive 21014 U.S.A. Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ 3 Noticed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked othe my lipiny or other traumatic event 2008. Be Marris Davidson Rose Sussman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark Siegel (Son) 502 Hemingway Dr., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 Denation Mt. Nebo Kendall 8/15/06 5 Other (Specify) Miami, FL 21. Sign ture of Puneral Service Licensee 22. Name and Address of Facility Levitt-Weinstein Memorial Chapel 5900 SW 77th Avenue, Miami, Florida 33143 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Hour Immediate Cause (Final disease or condition resulting in death) Physician ardio oul monary /Medical Due to (or as a consequence of): Examiner Mvocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit nronic Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Atria 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔏 No 2XER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending after death.

Director: Aft
d in by the fun 1 Yes 2 No М 2 Accident investigation 6 Could not be determined n 24 hours after de ne Funeral Directo pletely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Cartifying Physician: To the best of my knowledge, death conursed at the time, date and tides and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 11, 2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 hesapeake Drive, BelAir Maryland 21014 Sarbara 500 Degistrar's Signature 31. Date filed (Month,-Day, Year) 32. State Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Day Year **Physician** 3:00 рМ August 2006 Sauper /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Laurel regional Hospital Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, Year)
April 16, 1935 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Months New York 1 □ M 2 🙀 F 71 116-26-2211 Director Usuel Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Evantian must be notified at X☐Yes 2☐No Director Maryland Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20707 United States America 6611 Carleton Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be fited within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 ☐ No II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hananh Pantelmann Henry Mohring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; if Item 27 Ie m any injury or other traum once. 70 East Holly Avenue Sewell, NJ 08080 Metro T. Sauper Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 8/11/2006 Catonsville, Maryland 21. Signature of P n val Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel MD 20707 1 Kin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20 Months Metastic Small Cell Carcinoma Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (cr as a consequence of) Examiner led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Cthen 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🖄 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MA 8/10/2006 D22755 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Road # 260 Laurel Maryland 20707 Chritine Delima, MD 31. Date filed (Month, Day, Year) 32. Boistrar's Signatu State 2006 Registrar AUG 14

06-05967 Jayantilal Soni

Please Type of Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			- 2	Reg. 2. Date of Death		3. Time of Death
Medical Exami		Jayantilal S. Son	ni			Month D August 11, 2	pay Year 2006	2304 hrs
		4a. Facility Name (if not institution, give street and л		4b. City, Town, or I			4c. County of Death	
		Baltimore Washington Medical Cent		Glen Burnie		la = (m. u.	Anne Arundel	100
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	iay) If Under 1 Year Months Days			MM/DD/YYYY) 9. Birti Foreigi	n
Director		135-13-4749 1X M 2 F	59	Yrs.		Jan 22,	1947 Co.	<sup>intry)</sup> India
any	H	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	. ,		Pag	adena				1 Yes 2X No
daryłand 28a-f show 1 at once	랷	Maryland Anne Arunde 10e. Street and Number	L J Fas	10f. Zip Code		10g	. Citizen of What Coun	try?
ith the Maryland 23a or 28a-f sho n tified at once	ä	8105 Dewberry Circle		21	122		India	
with t	Funeral Director	11. Marital Status 12. Was De		13. Was Decedent of His	panic Origin? ( Spe	cify Yes or No-	14. Race - Americ	can Indian, Black,
death rr iten	Ĕ.	1 Never Married 2 X Married 1 Yes	Forces?	If Yes, specify Cuban		tican, etc.)	White, etc.	
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Your Dates:		1 Yes 2 X No				n-Indian
hours	9	15. Decedent's Education (Specify only highest gr		ecedent's Usual Occupat uring most of working life.			6b. Kind of Business/li	ndustry
36 iin 72 han "	E E		5 <b>+</b>	Accou	ntant		Accou	nting
d with	Completed	17. Father's Name (First, Middle, Last)	<u></u>		18.Mother's Name (	First, Middle, Ma		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Shantilal Soni			Hasum	ati S.	Soni	
21 nould I d Mer is man		19a. Informant's Name/Relationship (Type, Print )		Mailing Address (Stree				
MD nd 2 sho alth and m 27 is aumati		Tushar J. Soni/son		05 Dewberry			a, MD 21122 20c. Location - City or	
		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal	cremator	Disposition (Name of cer y or other place)	Λ110	Date 13,	20c. Location - City or	Town, State
Page Page		4 Donation 5 Other Specify:	west A	rundel Crem	atory 20	06	Odenton	, MD
Baltimore, permit. Pages I as Department of Her Important: If ite		21. Signature of Funeral Service Licensee		22. Name and Address Donaldson 1411 Annapo	of Facility <b>Funeral</b> H	lome & C	rematory,	P.A.
	-	23a. Part I. Enter the disease, or complications that	caused the death. Do not	enter the mode of dving.	olis Rd., such as cardiac or	Odento: respiratory arres	n , MD 2111. t. shock, or heart	Approximate Interval
Physician /Medical		failure. List only one cause on each line.				,		Between Onset and Death
Examiner			erotic Cardiovascula a consequence of):	ii Disease				<del></del>
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ord: w requisited should	e le					24a. Was ar autops	prior to d	topsy findings available completion of cause of
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Division of Vital Records, P.O. tal or stending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	To I	1 ✓ Yes 2 No		tpatient 3 DOA			esidence 6  Other	r: Scene
ding l		27. Manner of Death  1 Natural 5 Pending  28a. Da  (Moi	te of Injury hth, Day,Year)		ry at Work? Yes 2 No	zou. Describe ric	iw injury occurred	
SiO Atten r death ector: by the	cati	2 Accident Investigation	ace of Injury - At home, far			28f Location (St	reet and Number or Ru	ral Route Number, City
Divi	Certification:	Suicide Could not be determined (Specific		in, succe, factory, smoot	Julianing, Oto.	or Town, Sta		and read reading and
lospit 4 hour funerally fill		29a. Certifier		th occurred at the time. da	ate and place, and	due to the cause	(s) and manner as star	ted.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transity.	Medical	one) 2 Medical Examiner: On the basi	s of examination and/or in	vestigation, in my opinior	, death occurred at	the time, date a	nd place, and due to th	e cause(s)
To To	Me	29b. Signature and title of certifier	Stateu.	29c. Licens	se number		29d. Date signed (Mo.	nth, Day, Year)
		( lely of 1	1010	0.C.	M.E.		August 12, 2006	
		30. Name and address of person who completed ca			-			
	li (	Carol Allan, MD Assistant Medica		Penn Street, Baltim	ore, MD 21201			
	tate		Registrar's Signature	2846				
Regis	trar	WAT -	1					

			- FUI	partment of Health and Mertificate of Death	ental Hygier	2000 2000
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
	Physicia /Medic		Michael Sanner		putint 1	2 2001 4=24 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death
			Lorshyest Hospital	Agoda 9 stown		Bartimare
	Funeral	- 1	6. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		213-40-2105 66		Feb. 18,	1940 Maryland
	and w	- 1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary	ō	MD Baltimore Rei	sterstown		1 ☐ Yes 🏋 🕅 No
	the room	rec	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Country?
	3a or		54 Pendragon Court	21136		U.S.A.
	death	by Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
9	or its	Ī	Amped Forces?  **XNever Married 2   Married   Amped Forces?  **XNever Married 2   Married   Marr	1 ☐ Yes XX No Specify:	rican, etc.)	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow the Madical Exertifue fourt be notified at	d b	Year or Dates: 1963			Wille
5	72 h	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of workii b. DO NOT use retired)	ng 16b.	Kind of Business/Industry
12	then then	E G	Elementary/Secondary (0-12) College (1-4or 5+)	Gardener		Gardening
7	Hygie Hygie ther int, it		17. Father's Name (First, Middle, Last)		(First, Middle, Maid	
an	d be antai	o Be	Alfred Irving Sanner	Dai	sy Hamme	ett
Maryland	Shoul of Me mark	ပ		ailing Address (Street and Number or Rura		
	ulth ar 27 ie r trau		Brenda Williams / Niece 26	Bosley Lane; Re	eisterst	own, MD 21136
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: If Item 23a or 28a-f ehow importent: If Item 27 is marked other then "neturel", or Items 23a or 28a-f ehow nay Injury or other traumatic event, the Madical Examilmetmust be notified at once.		20a. Method of Disposition 20b. Place of Disposition	sposition (Name of Crematory or other place)	Date 20c.	Location - City or Town, State
Ę	Page nt: If ry or		1 Dunai 21/20Cremation 3 Desirioval from State	· ·	/14/06	Baltimore, MD
ati	mit. portr y Inju		21. Signature Funeral Service Ligens	22. Name and Address of Facility Eck	chardt Fu	neral Home P.A.
m	Deperiment of the periment of	9	Joeback from	1605 Reisterstov	vn Rd. Ow	ings Mills, MD21117
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between
8	Pnysician	60	Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions, b.			
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	and and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c			
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×	death certifical e attending phy d for use as th	₹ Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	2012-0-201		23d. Date of delivery
Вох	death a atter	ciar	in the past 12 months?  1 Vec. 2 No.  4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
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	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
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Division of Vital	or Al after of Direction by	Certification;	4 Homicide  4 Homicide  4 Homicide  4 See. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, St	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place	and due to the cause	e(s) and manner as stated.
	24 h 24 h Fur	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the within 2 To the complet	₹ E	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
)			Alice 1000 and	144397	4 AL	1845 12 2001
	4		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)		1
_			Alice Hsing Lavignest F	1017 Ital Rouse	Mitoun	phot 12,2006
	Sta		31. Date filed (Modin Day, Year) Registrar's Signature	2011		/ *
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year JOSEPH **EDWARD** SHIVERS 0852 AM August 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SaltimorE N/A Aa nes tosou ta If Under 1 Year | If Under 24 Hrs. 5. Social Security No 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. **№** M 2 F 71 219-30-6428 Director 20 1935 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Modical Examplicational be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1X Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4642 Rokeby Road 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: XXNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th N/A maintenance Abacus 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Edwards Estelle Shivers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Fair-sister 4642 Rokeby Road Baltimore, MD 21229 Baltimore, 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery 8/16/2006 4 Donation 5 Other (Specify) Baltimore MD 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee ) Carrill ruk 1101 E. North Avenue Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 40 Can dra will /Medical Due to (or as a consequence of): Examiner amorra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the ettending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) cete has been signed by the case 2 should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. 4 Mnknown Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? After this certificete has autopsy performed 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Naturaf 5 Pending Injury death. 1 TYes 2 TNo efter death. М investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 39543 address of person who completed cause of death (Item 23a) (Type, Print) Lenne Baltmore. Heschiggs 900 31. Date filed (Month, Day, Year) 32 Registrar's Signal re State 2006 Registrar 1

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** William 8 9 2006 Henry Scott 10:30p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caton Manor Nursing Home Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1**℃** M 2□ F Yrs. 230-42-6897 Director 71 1935 VA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ir then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No N/A Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2436 Lauretta Avenue 21223 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nt eny injury or other treumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) 4th N/A Foreman American Standard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Scott Rosa Beverly Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Scott, Jr. -son 2436 Lauretta Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩₩Burial 2 Cremation 3 Removal from State 8/14/2006 Arbutus Mem. Pk. Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the ettending physicien and defected for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D0062634 11/. 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWAN BALTIMIRE MD 21227 MATEEN 2717 HAMMUNDS FERRY RUAD 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State AUG 1 4 2006 Registrar

			1 - For State Registrar	State of Mi	arylanu /		artment of H rtificate of L		Mental Hy	Reg. No	2000	20014
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "neturel", or Items 23e or 28e-f show mayniqury or other traumatic event, the Medical Examinar matter incitied at ance.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 Yes XY  ff Yes, Give Year or Dates:		i	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes of N irto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
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	1 and 2 Health a em 27 la		Colonier Brow	n-Harvey	.er	422	8 Bonner	Road,	Balti	more	e, Md	21216
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7	/Medical		resulting in death)	a. Due to (or as	a consequence		NJAL	1407	Princori	7		lary
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, P.O.	that sed by deta		Part II. Dther significant conditions	contributing to death b	ut not resultin	g in the u	ınderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	quires n sign	ed by							1 🗆	Yes 2	□No 3□Pr	obably 4 Unknown
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	To the Hospital or Attending Phwithin 24 hours after death. To the Funers! Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying F (Check only 2 Medical Ex-	Physician: To the best iminer: On the basis of and manner st	f examination	dge, deat and/or in	th occurred at the time	ne, date and place pinion, death occ	ce, and due to the curred at the time	cause(s , date and	i) and manner as d place, and due	stated. to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** B. Irene 3, August 2006 9:45 lorrance /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 13676 Clarksville Pike Highland Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XX F Months Davs Hours Director 511-09-7409 92 June 4 1914 Iowa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28e-f ehow 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No Maryland Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23a Funeral 13676 Clarksville Pike United States America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel, or iter eay hijury or other treumatic event, the Medical Examina Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Library Arch. General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Orin Leslie Lord Sara A. M. McDonald 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Clevenger/Daughter 13676 Clarksville Pike Highland, MD 20777 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 8/10/2006 Brentwood, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORONALY **Physician** Zan 1 /Medical Due to (or as a consequence of) Examiner . A Carles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by Mx law ones 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s 24a. Was an autopsy performed certificate Division of Vital 1 Yes 2 No To the Hospitel or Attending Physician: After this certification, 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Medical Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and tyre of cer 29c. License number (110m 23a) (Type, Print)
11055 Little Parrison P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rea--3 31. Date filed (Month, Day, Year) State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene:

			Certificate of Death		g. No.	10 3	41667
			Decedent's Name (First, Middle, Last)	2. Date of Death Month		3.	Time of Death
	Physici /Medic		Charles James Talbott	August	9, 200	6 1	1:24 a.m.
)	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc		4c. County of	Death	
			8810 Walther Blvd. Apt. 2104 Parkvil  5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			imore	
	Funeral Director		Months Days Hours Min.	8. Date of Birth (Month, Day, ) May 15,	1907	Mary 1	(State or Foreign and
	fand ow		10a. State 10b. County 10c. City, Town or Location			10d. I	nside City Limits
	Many B-fsh	tor	Maryland Baltimore Co. Parkville			1	Yes 2/ No
	ith the	Olrec	10e. Street and Number 10f. Zip Code	10	g. Citizen of Wh	_	
	ath w	rail	8810 Walther Blvd. Apt. 2104 21234		United		
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 Is marked other then *natural', or Items 23a or 28a-f show apprintury or other traumatic event, the Modeal Examinate must be incitited at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rif Yes, specify Cuban, Mexican, Puerto Rif Yes, Specify:  14. Was Decedent Ever in U,S. If Yes, Specify Cuban, Mexican, Puerto Rif Yes, Specify:  15. Was Decedent of Hispanic Origin? (Specify: No If Yes, Specify Cuban, Mexican, Puerto Rif Yes, Specify: No If Yes 2 N	cify Yes or No- Rican, etc.)		American Ir White, etc.	
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7	led w lygier her th	Cor	12 yrs. Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First Middle M		el Ind	ustry
anc	should be filled vend Mental Hygies smarked other to	Be	Thomas J. Talbott Bridget				
7	should nd Me mark matic	မ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural			ate. Zip Cod	le)
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Ē	Page nent c int: If		I Al Burial 2 Li Cremation 3 Li Renioval from State	18/06	Baltimo	re, Ma	aryland
Baltimore, Maryland 21215-0020	permit. Departn Imports any Inje		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Leonard J. Ruck, Inc.	5305	Harfor	d Road	7-77.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			App	roximate rval Between
>	Physician /Medical Examiner		Immediate Cause (Final disease or condition ASCV)			Ons	set and Death
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σ.	thet the			1 🗆 Yes	3 2 <b>⊡″N</b> o 3	□ Probably	/ 4 ☐ Unknown
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5	hysic this ce al dire	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home			1-1	
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	7 # # C	Certification:	4 ☐ Homicide building, efc. (Specify)	City or Town,	State)		
	To the Hospital or Attending Physician: The is within 24 hours effer death.  To the Euhenel Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, en content of my knowledge, death occurred at the time, date and place, en content on my opinion, death occurred and manner stated.				
	To the Within To the	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (	Month, Day,	Year)
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DHMH 16 Rev 6/95

06-05872 Reed Williams

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar					Certific	cate of	Deatl	h			R	eg. No	4	ال		100
Physicia	an/	1. Decedent's Nam	e (First, Midd	le,Last)								2	. Date of Dea Month	ith Day	Year		3. Time of D	eath
edical Exami	ner		/illian										August 8,		Teal		0437 hi	rs
		4a. Facility Name ( Tracks belo		-				4	b. City, T Baltin	own, or Lo	ocation of	Death		4c. 0	County of	Death		
Funeral Director		5. Social Security I	Number	6. Sex		7. Age (I	n yrs. last bi	rthday)	If Unde	er 1 Year s Days	If Under Hours	24Hrs. Min.	8. Date of Bir	rth (MM/DI	D/YYYY)	Foreign	Mary⊥	and
Director		219-80-73		1 XM	2F		40	Yrs.					01/10/	1966		Cou	ntry)	
any		Usual Residence of	f Decedent 10b. County			10	c. City, Tow	n or Location	on								10d Inside (	City Limits
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hours afte "natural"	Completed	15. Decedent's E Elementary/Sec				1-4 or 5+)	eted) 16a	Decedent during mo		Occupatio king life. [				16b. Kin	d of Bus	iness/In	dustry	
21215-0036 ould be filed within 72 I Mental Hygiene s marked other than " ic event, the Medical	ed l	Elemental yroco	oridary (o 12)		1	,		Anto	Med	chani	C				Auto	mobi	10	
5-0036 Led within 7 Hygiene I other than	Ş	17. Father's Name	(First, Middle	, Last)				1100	- 1100			Name (8	First, Middle,			ino b i		
21215 Id be file Aental H narked o	Be (	Irvin Wi	lliams							l l	ary :							
21 hould I and Mer is mar	10	19a. Informant's N	ame/Relation	ship (Type	e, Print )		11	9b. Mailing	Address	(Street a	and Numb	per or Ru	ral Route <b>N</b> ur	mber, City	or Town	, State,	Zip Code)	
e, MD ; I and 2 shou Health and item 27 is r transmatic		Norma To		l / S	ister							t, B	altimo	re, l	Mary	land	1 2120	7
= ~ ~ = = I	H	20a Method of Dis		n 3	Removal f	rom State	20b. Place crema	of Disposi atory or oth			etery,		Date	20c. Lo	cation -	City or T	own, State	
Pages nent of ant: If or other	l II	4 Donation 5				70111 01210	Druid	l Ridg	ge Ce	emete	ry	08/1	6/2006	Pik	esvi	11e,	Mary	land
Baltimore, permit Pages I are Department of He Important: If ite injury or other tr	. 1	Signature of Fu	ineral Servi		1								Derric					
	0 0			4 6	1	~							., Bal					_
Physician /Mcdical		23a. Part I. Enter t failure. List or		on each	line.	1		not enter th	ne mode d	of dying, si	uch as cai	rdiac or r	espiratory arr	est, shock	k, or hea	rt	Approxima Between (	Inset and
Examiner		Immediate Cause or condition result			Multip												De	ath
7				h	e to (or as	a consequ	ience or)											
	ner	Sequentially list co	mmediate		e to (or as	a consequ	ence of):											
	Examiner	cause. Enter Und (Disease or injury events resulting in	triat irritiated	C.	e to (or as	a consenu	ence of):											
760, icate be executed physician and the burial - transit		events resulting in	death) Last	d.	0 10 (0) 20	a concequ	0.700											
e exectian ar	n/Medical	X UNPENDED	)		AMENDED	+cm#2'	3a,27,2	Qa_f n	orME (	~061 1	1 /0 /0	6 TTT						
8760, tificate be ng physici as the buri	Me	IF FEMALE:		- 1	23c. If yes,	outcome	of pregnanc	y	CITIE ,				V	23d.	Date of o	delivery		
Sox 687 leath certific e attending		23b. Was decedent past 12 month			1 Live		ne of death	2 Fet			Ectopic	pregnand	су	N	<b>l</b> onth	Da	эу	Year
Box e death c the atten ed for us	Physicia	1 Yes 2	No 9 Ur	len neven	9 Unkr		ie or death	5 Oth	ner (Spec	cify)								
D. B. It the de by the ached f		Part II. Other sign	ificant condi	tions co	ontributing	to death be	ut not resulti	ng in the u	nderlying	cause giv	en in Par	t I	23e. Did to	obacco us	e contrib	ute to th	ne cause of	death?
Division of Vital Records, P.O. as to Attending Physician: The law requires that the safter death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaxed in by the funeral director, page 2 should be detaxed.	d by												1 Ye	s 2 🗸	No 3	Proba	ably 4 U	Jnknown
rds, requir	Completed												24a. Was				opsy findings	
eco ne law te has	gm													rmed?	de	eath?		_
tal Recian: The certificate ector, page		25. Was case refe	rred to medic	al I		<del></del>				26 Place o	of Death (0	Check or		Z INO		<b>✓</b> Yes	2	No
Vita ysicia his ce direct	o Be	examiner?	2 No	Hos	pital: 1	Inpatient	2 ER/	Outpatient	3 D	OA O	ther <sub>4</sub>	Nursing	Home 5	Residenc	ce 6 🗸	Other:	Scene	
n of ing Ph	ı.	27. Manner of Dea			28a. Date	e of Injury th, Day,Year	28b	. Time of Ir	njury 2	28c. Injury	at Work?	2	8d Describe	how injury	occurre	d		
ion tendii eath tor: /	aţio	1 Natural 2 Accident		iding estigation			2006 4	:35 am		1 Ye	es 2 X	No	subject	t iumo	eđ			
ViS or At fiter d Direct in by	iţi	3 X Suicide		ild not be			y - At home,			office bui	ilding, etc	. 2	8f Location (	Street and	Numbe	r or Rura	al Route Nur	mber, City
Division spital or Attent hours after death meral Director:	Certification:	4 Homicide	dete	ermined	(Specify	<sup>)</sup> ra	ailroad	track	S			B	ound mai	rker 5	6.3 E	alti	nore, M	Douti
the Ho hin 24 the Fu	Medical	29a. Certifier 1 (Check only one) 2	Certifying I Medical Ex	aminer:0	n the basis	of examir							ue to the caus the time, date					
To To Con	Me	29b. Signature and	d title of certif		nd manner	stated		-	290	. License	number			29d. Da	ate signe	d (Mon	th, Day, Year	.)
		Same le	Bus	the 2	Ins	)				O.C.M	I.E.			Augu	st 8, 2	006		
Ø		30 Name and add	ress of perso	n who cor	npleted cau	use of dea	th (Item 23a	)										
T		Pamela So					xaminer	111 P	enn St	reet, Ba	altimore	, MD 2	1201					
Si Regis	tate trar		oth, Day,Year JG 1 4	2006	All a	Registrar's	Signature	Loss	No.									

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

			For State Registrar		Sta	ite of M	arylan		artmen rtificate			and Me	ental Hy	giene Reg. No.	0.0	5	25516
	: Dhoraini		1. Decedent's Name						N 11				2. Date of De	ath Day	Ye	er	3. Time of Death
	Physici /Medic			Jenni					Nall				August	10	20	06	1015 AM
	Examin	er	4a. Facility Name (If		1 /	and number) . ì e					r Location o			4c.	County of E	1 .	
FA -			Mercy N 5. Social Security Nu		5. Sex	7 40	a /In vrs	last birthday			If Under		8 Date of Bir	†h	100		100 C
1	Funeral Director		212-52-4		1□M 2		59	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 08 2		16	Coun	lace (State or Foreign try) MD
16.	D.		Usual Residence of D	Decedent					J				00 2				
	anylan show	_	10a. State	10b. County				y, Town or L								10	0d. Inside City Limits 1 X Yes 2 □ No
	Ba-f:	cto	MD	NA			Ва	ltimo									
	with ti	급	3900 Gle		Pose	3			10f. Zip		1229			10g. Citi	en of Wha		Iry?
	ns 23	Funeral Director	11. Marital Status	munc		is Decedent	Ever in U.	.S. 13.	Was Deced			ain? (Spe	cify Yes or No	)-	4. Race - /		an Indian,
(0	r Hen	Ξ	1 Never Marrie	d <b>XX</b> Marrie	d 1	ned Forces? ]Yes 2 💢 l		1				i, Puerto F	cify Yes or No Rican, etc.)		Black, V		
03	ral', o	Š	3 Widowed 4	Divorced	If Ye	es, Give ar or Dates:			1 ☐ Yes 2	ZALI No	Specify:				Specify:	В.	lack
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or terms 23a or 28a-f show haddeal Exato art must be notified at	Completed	(Specif	15. Decedent's y only highest	Education grade comp	oleted)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occup	ation during most	t of workin	g	16b. Kir	d of Busin	ess/Ind	Hustry Federal
121	Mithin 108.	ם	Elementary/Secon			llege (1-4or	5+)		anch						dit U		
	filed with Hygiene. other the		12th gra			na		DI	ancn	Ma			(First, Middle			,11 T	J11
an	Mental arked o	To Be	Lewis Ma			•					Dor	is B	urton		Í		
Maryland	S E E	-	19a. Informant's Nar	ne/Relationshi	p (Type, Pri	int)		19b. Mail	ng Address	(Street a	and Numbe	or Or Rural	Route Numb	er, City or	Town, Sta	te, Zip	Code)
	1 and 2 Health a em 27 le		Fred Wal	llace-	Husba	and						Road	, Bal	timo	re,	Md	21229
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 Bny injury or other tr once.		20a. Method of Dispo		Bamovs	al from State	20b. F	Place of Disp cometery, cre	osition (Nam matory or o	ne of ther plac	ce)	Da	ate	20c. Lo	cation - City	or To	wn, State
<u>Ë</u>	F Part F		4 □ Donation	5 ☐ Other (Spe	city)	ar iroin otate	Ki	ng Me	emori	al	Park	8/1	7/06	Rar	dall	st	own, Md
3alt	permit. Pag Department Important: I sny injury o		21. Signature of Fun	eral Service Li	censee	V1			2. Name an								
	a∩ = a ot			yree	w,	170	resi						Balti		e, mo	1 .	21215
			23a. Part1. Enter the shock, or heart		nly one cau	se on each li		7 4		e of dyin				rrest,			Approximate Interval Between Onset and Death
· 100	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	-inai	a			14,6	ole_		mys	lone	1			_	
	Examiner			1	· '	Due to (or as	a conseq	uence or):									
	-15 A	Je.	Sequentially list con- cause. Enter Underl Cause (Disease or in that initiated events	ditions,	b	Due to for as	a conseq	uence of):								+	*
1	cuted nd ransit	Examiner	Cause (Disease or in that initiated events	njury	c												
,092	e exe sian a urial-1	E	resulting in death) La	ast	=	Due to (or as	a conseq	uence of):									
876	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	dlcal		'	d											_	
89 X	ding g	Physician/Med	IF FEMALE:		23c. If v	es, outcome	of pregna	ancv							3d. Date of	dolina	<u></u>
Вох	eath etten for u	clan	in the past 12 m	nooths?	10	Live birth Pregnant a	2 Feta	Ideath 3	□Ectopic pr □ Other (sp		1				Month		Day Year
0	the d by the ached	hysi	1 ☐ Yes 2 ☑ 9 ☐ Unknown	NO		Unknown			, ,								
ري م	ires that the death signed by the ette d be detached for	by P	Part II. Other signific	cant condition	s contributi	ng to death b	out not res	ulting in the u	underlying c	ause givi	en in Part I.		23e. Did	tobacco u	se contribu	te to th	e cause of death?
rd	w require been sig should b												1 🗆	Yes 2	No 3	] Proba	ably 4 🗆 Unknown
Records,	law re as be 2 sh	Completed											24a. Was				osy findings available
E .	: The law cate has a	Con											perfo	2 No	deat	h?	2□ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referre examiner?	ed to medical	Hospita	r = 2000				Oth		of Death	(Check only	one)			
of	this ral dir	- T	1 Yes 2 7			" 1 Inpation. Date of Inju		ER/Outpatie		8c. Injun	4 🗆 14 u	-	ne 5 ☐ Resi 8d. Describe			Specify	)
on	ding Phy th. After thi funeral	tlon	Natural 2 Accident	5 Pending		(Month, Da	y Year)	Injury	M	Worl	k? Yes 2 ∐ I		ou. Describe	now injury	00001100		
Division	I or Attending after death. Director: After in by the funer	Ilca	3 Suicide	6 Could no	t be	. Place of In	jury - At h	ome, farm, si	reet, factory							r Rurai	I Route Number,
Ö	s afte el Dir	Certification:	4 Homicide			building, et	tc. (Specif	<b>y</b> )					City or To	wn, State,			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Medical	29a. Certifier (Check only one)	Certifying	xaminer: O	To the best n the basis o nd manner st	of examina	owledge, dea ation and/or in	th occurred nvestigation,	at the tin	ne, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and t	itle of certifier	1				290	. License	e number			29d. Date	signed (N	lanth, L	Day, Year)
			▶ %	M I	my	1				Di	4085	4		(	8/10	12	006
	8		30. Name and addre	ss of person w	ho complete		death (Iter	n 23a) (Type	Print) SA F	2-1	Place		B., 14,	more.	2	120	2
34	Sta		31. Date filed (Month		2005	32 Tegisti	rar's Signa	ature /	ask								
	Regist	ar	A	UG 1 4	2006	A SEL	an s	19	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM I per PHYS. #19a, per PH, C860, 10/13/06, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

a	For
7-	State Registrar

			Registrar				Ce	TUI	icale of i	Jean	<u> </u>		Reg. N	0.		
	Physici	an	1. Decedent's Name	P // A /	SHARADKA	NIA	I. V	A)	DYA O L	1		2. Date of De	D	ay	Year	3. Time of Death
	/Media			DEAN				V	リレリー	H		Haga			X06	23017 11
1	Examir	er	4a. Facility Name (I	f not institution, give			- \		b. City, Town, or	Location	of Death			c. County o		
			The Jd			2611	101		Baltimore				B	altimo	re	
	Funeral		5. Social Security N		x 7. Age □M 2.□F	e (In yrs. la	st birthday		Onths Days	Hours Hours	Min.	8. Date of Bi (Month, Di Sept • 18	rth ay, Year	The l	9. Birthp Goul India	place (State or Foreign htry)
	Director		220-35-7013		x-1	85	Yrs.	]			1	Sept. 18	3, 19	21	India	
	pu &		Usual Residence of 10a, State	10b. County		10c City	Town or L	ocat	ion							0d. Inside City Limits
	aryla	_	Tou. State	TOD. COUNTY		roo. Oity,	10000 01 2	·	1011							1 ☐ Yes 2 ☐ No
	8 -4 W	cto	Maryland	Howard		Laur	el									
	ih th or 22	Directo	10e. Street and Nu	mber					10f. Zip Code				10g. C	itizen of W	hat Cou	ntry?
	23a		9227 Pinen	ut Court					20723				Un	ited S	tates	America
	eeb ee	ner	11. Marital Status		12. Was Decedent E Armed Forces?	Ever in U.S	5. 13.	Wa	s Decedent of H	ispanic O	rigin? (Spec	cify Yes or Ne	0-		- Americ	ean Indian,
ဖွ	or it	F	1 Never Marr	ied 2 Married	1 ☐ Yes 2 K N II Yes, Give	lo			Yes 2□ No	Specify				Specify:		
8	ours	9	3 ☑ Widowed	4 Divorced	Year or Dates:				1103 ELX.110	Ороспу				эреспу.	Asi	an
ည	72 hours after deeth with the Maryland Instural, or itama 23a or 28e-f ahow Ulcal Examinar must be medified at	Completed by Funeral	(Spec	15. Decedent's Edi	ucation de completed)		16a. Dece	eden	t's Usual Occup d of work done o	ation during mo	st of workin	а	16b.	Kind of Bus	siness/In	dustry
7	within ene. then	du	Elementary/Seco		College (1-4or 5	+)	life.	DO	NOT use retired	1)		•	0			
7	e filed within at Hygiene. I other than vent, the Mo	5	12				House	WII	'e				UW	n Home		
ğ	be filed tal Hygid d other avent, II	Be (	17. Father's Name	(First, Middle, Last)						18. Moth	er's Name	(First, Middle	, Maide	n Sumame	9)	
<u></u>	should be nd Mental marked o	S C	Unobtaina	ble						Unob	tainab	l e				
3	Short and h		19a. Informant's N	ame/Relationship (T	ype, Print)		19b. Mail	ling /	Address (Street	and Numb	er or Rural	Route Numb	er, City	or Town, S	State, Zip	Code)
Ž	nd 2 lift a 27 ts		Niranjan l	VALDYA			9227	Pi	nenut Cou	ırt L	aurel	Marylar	nd 2	0723		
ō,	s 1 and 2 should be filed within 72 hours after deeth with the Marylan I Health and Mental Hygiene. Itam 27 is marked other than *natural; or itams 23e or 28e-f ahow other traumatic avant, the Maxilcal Exercities result be inclifted at		20a. Method of Dis	position		20b. Pla	ace of Disp	ositi	on (Name of	- 1	Da	ate	20c.	Location - (	City or To	own, State
2	Pages nent of int: If it			Cremation 3 🗆					ory or other place	·	0.10.10					
Baltimore, Maryland 21215-0036	it. P			nera Service Licens		Balt			shington ( ame and Addres	1911		006	Lau	rel, M	aryla	ind
Ba	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other once.		Z1. Signa	10	1 Julian						•	Sandy Sr	rina	Poad	Laure	1 MD 20707
			220 Pagt Folds	Mar 7	lications that caused	the death								Road	Laure	Approximate
			shock, of hea	in failure. List only o	one cause on each lin	10.						respiratory a	aiiosi,			Interval Between Onset and Death
1	Physician		Immediate Cause disease or condition	(Final on	a. INTRA	CRA	WIAL		HEMON	CR HA	GE					PDAYS
	/Medical Examiner		resulting in death)		Due to (or as											
	Exammer		Sequentially list co	anditions .	b											
5	D ==	ner	cause. Enter Under	arlying	Due to (or as	a consequi	ence of)									
	ocute nd trans	Examiner	Cause (Disease or that initiated events	injury	c											
ó	h certificate be executed ending physician and r use as the burial-transit	Ĕ	resulting in death)	Last	Due to (or as	a consequ	ence of):									
68760,	ate by	in/Medicai			d											
39	ng pt as t	Jed	IF FEMALE:					_								
ŏ	£ 0.	2	23b. Was deceden	it preignant	23c. If yes, outcome 1 ☐ Live birth			ΠEα	topic pregnancy	,				23d. Date		,
œ.		Sicial	in the past 12 1 Tes 2	Z No	4☐Pregnant at 9☐Unknown				ther (specify)					Mon	ith	Day Year
0.0	The law requires that the deat ate has been signed by the att page 2 should be detached for	Physicia	9 Unknown		9LI OTIKITOWIT			_						-		
	ant st gned e de	by P	Part II. Other signi	ficant conditions co	entributing to death bu	ut not resul	Iting in the	unde	erlying cause give	en in Part	t.	23e. Did	tobacco	use contri	bute to t	ne cause of death?
Records,	quire an sig uld b											1 🗆	Yes	2 □ No	3 🗌 Prob	pably 4 Unknown
8	s bee	Completed										24a. Was		24b. W	ere auto	psy findings available mpletion of cause of
æ	he lav e has age 2	E										auto	ormed2 2 <b>X</b> N	di	eath?	• /
Ø			25. Was case refer	red to medical						OF Place	a of Dooth	1 ☐ Yes (Check only		10 1	☐ Yes	2 <b>X</b> No
5	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 💢	/	Hospital:	nt 2 🗆 E	R/Outpatie	not.	3C DOA Oth	or		ne 5 ☐ Res		€ □Otho	r (Coope	
ō	Physic ruthis aral di	To	27. Manger of Dear		28a. Date of Injui (Month, Da)		28b. Time	-	28c. Injun			8d. Describe				у)
0	ding h. h. After funer	tor	1 Natural	5 Pending investigation	(Month, Da)	Year)	Injury			k? Yes 2.⊑				•		
S	Attending r death.	ca	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not be	28e. Place of Inju	ırv - At hor	ne farm s	treet				8f. Location	(Street a	and Numbe	r or Bur	al Route Number,
Division of Vital	i or Attand after death Director:	Certification:	4 Homicide	determined	building, etc	. (Specify)	)		, 1401017, 011100			City or To	wn, Sta	te)		
_	Hospital 4 hours a Funaral tely filled		29a. Certifier	1 Practituing Phy	reining. To the best of	al mu know	dadaa daa	th o	acused at the tim	na data a	od place a	nd due to the		(a) and a seri		
	To the Hospital or Attending I within 24 hours after death.  To the Funersi Director: After completely filled in by the funer	edicai	(Check only one)	2 Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examinati	on and/or	nves	tigation, in my o	pinion, de	ath occurre	d at the time	, date a	nd place, a	nd due t	tated. o the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and	tide // entifier	and manner sta				29c, Licens	e number			29d. D	ate signed	(Month.	Day, Year)
	T.¥T.8		Loss organization date													
				10					CE	0			W	das	1	4,2000
	2		30. Name and a w	ress of person who o	completed cause of d	eath (Item	23a) (Type	, Pri	nt)					12.	1.1	2,2006
			MUAM	JCHIA	I Phi) M.	D 60	$\mathcal{N}$ .	И	101te St	13/	4LTI.	MORE	, N	1D 0	411	<i>Y'</i> /
1	Sta		31. Date filed (Mer	•	32- Registra	ars Signati	nte	P 1-	~ ·							
	Regist		A	UG 1 4 200	6 Renews	1	10	4	Es)							
DH	MH 17 Rev 1/2	001					-									

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 2006 **Physician** August 8, Рм 9:00 Joseph McDonnell Wyatt /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris Hospice If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Aug. 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 XM 2 ☐ F Yrs. Director Mary l'and 717-10-6464 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ehow : if item 27 is marked other then "naturel", or items 23s or 28s-1 sho or other treumstic event, the Madical Examinar must be notified at 1 Yes 2 No **Funeral Director** Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Theo Lane 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐XNo 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ۵ Yes, Give 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ni eny injury or other treumatic event, the Media 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) & Sales Wine Spirits 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen McDonnell Francis Wyatt ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Theo Lane Towson, Maryland 21204 Mrs. Rebekah B. Wyatt/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) Entomb Dulaney Valley Mem. Grd. 8/12/06 Timonium, Maryland 21. Signature of Funeral Service Lices 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sate has been signed by the ettending physicien and page 2 should be detached for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760 by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 A No certificate 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6X Other (Specify) ဥ 1 Yes 2 XNo 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1X Natural Division 5 Pending investigation death. 1 Yes 2 No nerei Director: A filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel Completely filled 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State AUG 1 4 2006 Registrar

2006

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AUGUST

JOSEPH WYATT

			1- Stote Amend #13 Per FH	te of Maryland G858 8/14/	1 / Depa 06 JH Cei	artment of H rtificate of L	ealth a D <i>eath</i>	nd Mental Hy	giene	06 25519
	Dhuaisi		Decedent's Name (First, Middle, Last)		,	1-115	-1/	2. Date of De Month	ath Day	3. Time of Death
	Physici: /Medic		HIDA		U	TILL	7	AUGUST	r 9 2	006 17:00 PM
1	Examin	er	4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of	Death	4c. County	of Death
			SOHNS HOPKINS BAYVIEW			BALT	ZIM CI	CE		
	Funeral		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. Ia	ist birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, Da	th ly, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	74				reb. Z	0,1932	Paraguay
	viand ow		10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
	Man	호	MD Baltimore		Ow	ings Mil	l1s			1 ☐ Yes XXNo
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	deeth with the Maryland ims 23s or 28s-f show rmust be notified at	a	12378 Greenspring	Ave.		211	17		U.S	5.A.
	eep .	Iner	11. Marital Status 12. Wa	s Decedent Ever in U.S ned Forces?	S. 13.1	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	in? (Specify Yes or No Puerto Rican, etc.)		- American Indian, k, White, etc.
36	or it	by Funeral Director	SZ-SZ If Y	]Yes <b>2,∏</b> Yo es, Give	4	es 2000	Specify:		Specify	
Ö	72 hours after neturef, or Ite		15. Decedent's Education	ar or Dates:	16a Dagg	dent's Usual Occupa	-ti-e		10h Kind of Bu	
<del>7</del>	n 72	Completed	(Specify only highest grade comp		(Give	kind of work done of DO NOT use retired	furing most	of working	16b. Kind of Bu	siness/industry
12	within iene. then	E	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		Homemak	•		0.7	n Home
b	a filed value of the r	0	17. Father's Name (First, Middle, Last)					's Name (First, Middle		
an	Mental Rental Red Check	To B	Antonio Catald	0			E	milia F	iore	
Maryland 21215-0036	and Men Is marke		19a. Informant's Name/Relationship (Type, Pri	"baughter	19b. Mailir	ng Address (Street a	and Number	or Rural Route Numb	er, City or Town,	State, Zip Code)
	is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Heeth and Mental Hygiens of the terms 23a or 28a-f show item 27 is marked other than "neturer, or items 23a or 28a-f show other traumatic event, the Madical Exeminar must be notified at		Catalina McHenry De		710	St.Paul	Ave	. Reister	stown,	MD 21136
Baltimore,	0 0		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ Remova	20b. Pla	ace of Dispo	sition (Name of matory or other place Veterar	e)	Date	20c. Location -	City or Town, State
Ĕ	Pa Pa		4 Donation 8 Other (Specify)	Mary	Ceme	terv		8/15/06	Garris	on Forest, MD
3a I	permit. Departr Imports any inju		21. Signature — uneral Sovice Licensee		22	. Name and Addres	s of Facility	Eckhardt	Funera	1 Chape1P.A.
_	405 e d	1	Tuepad In	unu -						Mills,MD21117
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause	se on each line.			_		rrest,	Approximate Interval Between Onset and Death
*	Physician		Immediate Cause (Final disease or condition resulting in death)	SUBACAC,	HNOI	O HEN	DORI	CHAGE		2 digys
۲	/Medical Examiner		resulting in obality	Due to (or as a consequence	ence of):	,				
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16	nted Insit	min	cause. Enter Underlying Cause (Disease or injury							
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8760,	death certificate be executed e ettending physician and ad for use as the burial-transit		d							
9	tifica ng ph as th	ledi				· <u>-</u>				
Вох	eath certific ettending pl	an/N	230. was decedent pregnant	es, outcome of pregnant		Ectopic pregnancy				e of delivery
	e dea he ett	Physician/Medical	1 Yes 2 No	Pregnant at time of de		Other (specify)			Mor	nth Day Year
P.O.	that the de ned by the e detached t	Phy	9 Unknown		Minn in Alin		'- D-41	920 Did		Shara and a same of decade 2
	9 P 9	þ	Part II. Other significant conditions contribution	ig to death out not resul	iting in the ui	nderlying cause give	min Parti.			ibute to the cause of death?  3 Probably 4 Unknown
Ö	w requir been s should	etec			****				1	
Sec.	sicien: The law s certificete hes t lirector, page 2 s	Completed						24a. Was	psy p	Vere autopsy findings available rior to completion of cause of leath?
a			05 W.					1 ☐ Yes	2 No 1	Yes 2 No
₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospita	l: 1 Inpatient 2 E	ER/Outpatier	t 3 DOA Cthe		of Death (Check only of sing Home 5 Resi		
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Division of Vital Records,	l or Attencatter death after death Director:	tific	3 ☐ Suicide 6 ☐ Could not be 28e	Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location ( City or To		er or Rural Route Number,
Ö	tal or rs afte si Dir ed in	Certification:		ounding, otc. (opeany)	, 			0.,, 0.	, Oldio)	
	To the Hospital or Attending Physician: within 24 hours atter death.  To the Funarei Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physicien: (Check only 2 Medical Exeminer: O	To the best of my known the basis of examinati	vledge, death	n occurred at the tim	e, date and	place, and due to the	cause(s) and mai	nner as stated.
	thin 2 the I	Med		d manner stated.		200 Lineau			und Data data	March Day V
	To To		2/2	-, m.D.		RI	5-11	00	ALLEIST	- 9. 2006
	1.		30 Name and address of parent who complete	ed cause of do-th (tra-	22a) /T-n-	Print\		-	1-100-1	7 2500
	10		DR. SAMES L. FRAZ	TER 4941	ETAST	ERN AVER	UE .	BALTEMERS	Juno :	21224
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signate	ure	W.			-	· · · · · · · · · · · · · · · · · · ·
	Registr	ar	31. Date filed (Month, Day, Year) AUG 1 4 2006	Elever St	Light					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** Helena en /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Good Samaritan Nursing Home Baltimore N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, July 2, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 X F 82 216-16-3557 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Exercises must be notified at 1 ¥ Yes 2 □ No N/A Maryland Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3900 Southern Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3√Widowed 4 □ Divorced Be Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bar **Owner** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna Staller Edward M. Shipley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and i 19a, Informant's Name/Relationship (Type, Print) Health tem 27 221 Quaker Ridge Road Timonium Maryland 21093 Kathleen Moriarity/Friend Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 8/11/06 Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Hartord Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final la **Physician** tela disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the Records, P.O. 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown should t Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 1000 page 2 has certificate Division of Vital 26. Place of Death (Check only one 25. Was case referred to medical examiner' Other: Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) sidi 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funeral D the Hospitel 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of ceffifier limore, Kd-2 person who completed cause of death (Item 23a) (Type, Rmit) 60 31. Date filed (Mo 32. Sgistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene UU b Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** James B. Addington /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Square Hospita Hours Min. 8. Date of Birth (Month, Day, May 10 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 1924 Days Months 225-24-0473 1 XM 2 ☐ F 82 Yrs. Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County nem zr remarked other then "natural", or items 23s or 28s-f ehow other treumatic event, the Medical Examinar must be notified at 10a. State 1 ☐ Yes 2 ☐ No Middle River Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Fir Drive 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Buchanan Arnold Addington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Fir Drive Baltimore MD 21220 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Heelth and Important: If Item 27 ien any Injury or other treun Ada F. Addington /wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 08/12/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave Balto MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only an eause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cholangitis Physician a ASCENding /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Attending Physician: The law recuires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) beer signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? s certificate hes t lirector, page 2 s death? 2 No 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) MD D005837 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Square Dr. Baltimore MD 21237 Dr. Myas, Thein GOOC 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 15 State 2006 

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 940 2006 ARROWOOD AUGUST 2 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. A. Date of Birth (Month, Day, Year)

Hours Min. March 23, 1941 JOHNS Hopkins Sitting If Under 1 Year Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days 15 M 2□F 246-60-3407 65 Yrs. Director NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Itame 23a or 28a-f ehow the Medical Examiner roust be notified at Lincolnton GA Lincoln 1 ☐ Yes 2 🔀 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30817 USA 4550 Chamberlain ferry Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or item eny injury or other freumatic event, the Medical Examinations. 1 ☐ Yes 2 S No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Heavy Equipment Elementary/Secondary (0-12) Coltege (1-4or 5+) Business Owner 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katie Lee Blankenship Merrill Wilson Arrowood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda E. Arrowood/Wife 4550 Chamberlain Ferry Road Lincolnton, GA 30817 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Martins Crossroad August 15, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincolnton, GA 2006 Church Cemetery 21. Signature of Fune al Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or conditications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MuHi-Organ

Due to (or as a consequence of): **Physician** System Failure /Medical Examiner Acute Distress Syntone Respiratory Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sete hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit Jersis Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? After this certificete hes 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Naturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) REJ-000

State Registrar

STREET

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUL-KA

31. Date filed (Month, Day, Year)

AUG 1 5 2006

600

N. WOLFE

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:53 AM 2006 **Physician** August Joanne Atiles /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 3 F 68 Yrs. 068-28-4873 1938 New York Mar Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Maryland 10a. State 10b. County rai', or items 23a or 28a-f ehow Examiner must be notified at 1 XYes 2 No Maryland Anne Arundel في Annapolis Direct with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21409 1464 Log Inn Rd. Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Marned SpecifyPuerto Rican Specify: White Baitimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Md. 12th 6yrs <u>Certified Public Accountant</u> and Mental Hygier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edelmira Santana Louis Atiles 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a 1464 Log Inn Rd. Annapolis, Md. 21409 Hazel Coates(Friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Metro Crematory or other place 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-15-06 permit. Page Department o Important: If eny injury or Baltimore, Md. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. 1. Reese Moc 483 821 West St. Annapolis, Md. 23a. Part1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ing cancer LANS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year in the past 12 months? Month detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, should be 1 

Yes 2 

No 3 

Probably 4 

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has director, page 2 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To this 28c. Injury at Work? filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 4 hours after death Funeral Director: 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Trad Bah, HO D46052 30. Name and address of person who complete oleted cause of death (Item 23a) (Type, Print) on hway anna polis, MD 32. Restrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

		1- State Amend #26 Personal Amend *26 Personal Amen	State of Marylan er Phy G858 8,	d/Dep /15/06	artment of H	lealth and Death			25524
Dhyai	30	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
Physic /Med		Anna	Catherine	Brio	ce		August	8 200	2:00P M
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Deat	h	4c. County of De	eath
		Chesapeake Hospi			Linthi				rundel
Funera		5. Social Security Number 6. Sex	IM 2DE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year)	Birthplace (State or Foreign Country)
Directo		215-10-8536 Usual Residence of Decedent	91	113.			Sept. 1	0,1914  M	laryland
and wo		10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. fnside City Limits
Mary	ō	M - 1 - 1 A A		D	1				1 ☐ Yes 2 ☐ No
the f	Director	Maryland Anne Aru	nuei	rasa	adena 10f. Zip Code		10	og. Citizen of What	Country?
with a or	<u></u>					2			S.A.
RIC 21213-UU30 be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or items 23e or 28e-f show event, the Modical Exprinential transitied at	Funerai	600 Curran Road	12. Was Decedent Ever in U.	S. 13.	2112 Was Decedent of H		Specify Yes or No-		merican Indian,
fer d	들	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		ff Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, W	hite, etc.
urs a	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
Baltimore, Maryland Z1Z13-UU30  semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.  mportant: If liem 27 is marked other than "natural", or any halury or other traumatic event, the Medical Expri	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation	1	16b. Kind of Busine	
hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most or wo	rking		
N Down	μÖ	9	N/A	Me	eat Packe	r		Albert F.	Goetz
be filed within tal Hygiene.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	Maiden Sumame)	
Mantis Aentis riked	To E	Theodore		Ellio	t l	Marie		E	Ballenger
Tarylan 2 should be and Mental 16 marked of	1.	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Number,	City or Town, State	e, Zip Code)
lore, Maryla ges 1 and 2 should it of Health and Men iff Item 27 is marks or other traumatic		Thomas Brice (Son)	)	600	Curran :	Road Pas	adena. Ma	ryland 21	122
S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1	1 .	20a. Method of Disposition		lace of Dispo	osition (Name of matory or other place	(e)	Date 2	20c. Location - City	or Town, State
Page Page nent c		1	1	+ Holy	r Redeeme	r Com 8	/12/06	Paltimore	. Maryland
Daltimore, Mi permit. Pages 1 and 2 Department of Health s Important: if Item 27 is any Injury or other tra		21. Signature of Funeral Service Licens		2	Name and Addre	ss of Facility			, introduced
Deparament of the control of the con		the F	Tolling .	Mo	Cully-Po	lyniak F ain Road	uneral Ho Pasadena	me, P.A.	d 21122
Fig. at		23a. Part Enter the disease, or complished, or heart failure. List only or	ications that caused the death						Approximate fnterval Between
flicate be executed  Thysicien and the burial-transit		resulting in death)  Sequentially fist conditions, if any, fleading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	=				
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he Hospitel of in 24 hours at he Funeral Dietely filled it	edicai	29a. Certifier 1 Certifying Phy: (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner ate and place, and o	as stated. due to the cause(s)
To the Partition 2. To the I	Σ	29b. Signature and title of certifier			29c. Licens		29	9d. Date signed (Mo	onth, Day, Year)
		Muney	MD		05	7531	A	rigust	9,2006
11		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,	Print)				
[ ]		30. Name and address of person who co	601 Vitera	ans	Hwy,	Millers	ville,	ND 2	1108
	tate	31. Date filed (Month, Day, Sear)	22. Registrar's Signa	ture for	Ma				
Regis	trar	AUG 1 5 ZUUD	AND MESON OF THE PARTY OF THE P	No Barre					

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	E		Decedent's Name (First, Middle, Last)					2	. Date of Dear		3. Time of Death		
	Physicia /Medic		Lois F. Bosse					A	August	11, 2006	2:47 p M		
	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town,				4c. County of Death Anne Arunde1			
		\$6.	2605 Chapel Lake Drive				rills	0.11					
	Funeral		5, Social Security Number 6. Sex 7. Age (# 1	n yrs. last birt	thday) _ Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	48367 Bin	<b>1933</b> 9. Bi 2006 Kei	rthplace (State or Foreign country)		
	Director		Usual Residence of Decedent				1	1 7	14g. 11	, 2000 Ke	Itucky		
	yland		10a. State 10b. County 10	c. City, Town							10d. Inside City Limits		
	a-f s	ctor	Maryland Anne Arundel	Gambr	ill	S		<u> </u>			1 ☐ Yes 2 No		
	or 28	Director	10e. Street and Number			10f. Zip Code	010	<i>.</i>	1	Og. Citizen of What C	country?		
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and	be file ital Hy id othe event,	Be (	17. Father's Name (First, Middle, Last)							Maiden Surname)			
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Mar	12 ha 7 ls		James F. Bosse (Husband)							r, <i>City or Town, State</i> , s, Marylan			
ē,	- i = =		20a. Method of Disposition	20b. Place of	Dispos	sition (Name of platory or other pla	ice)	Dat	te	20c. Location - City o	r Town, State		
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			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do r	not ente	or the mode of dy	ng, such as	cardiac or i	respiratory arr	est,	Approximate Interval Between		
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Vital		0	25. Was case referred to medical				26. Place	e of Death (	Check only of		5 2010		
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UIVISION	el or Attendir s after death. I Director: Af d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (	<ul> <li>At home, fa</li> <li>Specify)</li> </ul>	ım, stre	et, factory, office		28	If. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physicien: To the best of n	ny knowledge	e, death	occurred at the t	me, date ar	nd place, an	d due to the c	ause(s) and manner a	as stated.		
	he Ho n 24 h he Fu pletet)	edical	(Check only one)  2 Medicel Examiner: On the basis of exam and manner states		d/or inv	estigation, in my	opinion, dea	ath occurred	at the time, d	late and place, and du	e to the cause(s)		
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			reesen reel	41	UL	/ DS	7/	77		8-13	-06		
	Q		30. Name and address of person who completed cause of deal D2. ALLEN REJULY POS		(Type, I	Print) DIOWAY	P AVE	e, m	T. A) 4	ey, mo.	21771		
	Sta		31. Date filed (Month, Day, Year) 32. Redistrar's	Signature		hall :							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** 8, 2006 Marleen J. Bennett August 11:35 p<sup>M</sup> /Medical 4a.Fecility Name (If not institution, give street and number)
Bel Air Health & Rehabilitation 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | Feb 15 1951 | Maryland Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□ M 2√F 219-52-9990 55 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits h and Menial Hygiene. 7 ie marked other then "natural", or liems 23a or 28a-f ehow treumatic event, tre Medical Examinar must ke notified at PA 1 ☐ Yes 2 XNo York Delta Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 59 Scarlet Oak Trail 17314 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmarne)
Magdaline Wornsdofer Be George Weltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a cortent; If item 27 le Jackie R. Bennett 59 Scarlet Oak Trail Delta, PA 17314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Importent; If eny injury or once. Oak Lawn Cemetery | 08/11/06 | Baltimore, Maryland 21. Signature of Fun al Sento Lic 22. Name and Address of Facility 300 Mace Ave Balto. Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -2 yrs Due to (or as a consequence of): cano /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence off-The law requires that the daath certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital fo the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) ₽ 1 Yes 2 No this s after death.
I Director: After this of in by the funeral d 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred 1 ANatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral DI completaly filled in 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56545 hosle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR, MA 21014 KHOSLA 206 HAYS ST #102 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1015 PM ANETTE August 2006 11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** MEMORIAL HOSPITAL .TIMORE UNION If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2X F 217-84-4560 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show Item 27 ie marked other then "naturel", or iteme 23a or 28a-f eho other traumatic event, the Madical Examinar must be notified at 1AYes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ARE GIVER ENTER FOR SOCIAL CHANGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lijury or other traumatic event 9008. Be MAR PARNES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of 21. Signature of Fun ral Service Lide Rou . FUNERAL HOME 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) fneu monia /Medical Due to (or as a consequence of) Examiner AID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Yunknown Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death sate has been signed by the a page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 100 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 ANatural 5 Pending 1 Yes death. investigation 2 Accident within 24 hours efter deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 | Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD AT2438946 August 11 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital Baltimore . MD K Union JUCELYNE KOUATCHOU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5 200\$

			State of Maryland / Department of Health and I  State of Maryland / Department of Death  Certificate of Death	Mental Hyg	iene	25528
			Negistrar  1. Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
	Physici /Medic		Patrice M. Bruchac	A Wegth 1	.3 <sup>Day</sup> 2006 <sup>Year</sup>	12:50AM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death	
	V 44		Oak Crest Care Center Parkville		Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day NOV 1	9. Birthp	place (State or Foreign htry) NY
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	-		0d. Inside City Limits
	Marylar i-f show	tor	MD Baltimore Parkville			1 ☐ Yes 2 € No
	th the or 28a	Funeral Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cour	ntry?
	ath wi	rai	8832 Walther Blvd 21234		USA	
	tame	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes   1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes  1 □ Yes	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
<u> </u>	ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hyglene. d other than "naturel", or itams 23e or 28e-f show event, the Medical Exercities must be notified at	Ď	1 ☐ Never Married 2 ☐ Married  1 ☐ Yes ♣ No If Yes, Give Year or Dates:  1 ☐ Yes 2 ☐ Yoo Specify:		Specify: Whi	te
ر کے ا	natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking	16b. Kind of Business/Inc	
	Ind ZIZIS be filed within 73 tal Hygiene. d other than "n.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)  12  College (1-4or 5+)  Homemaker		Own Home	
o i	Maryland 2 2 should be filed v n and Mental Hygie 1/8 marked other reumatic event, III	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle, i		
<u> </u>		10	Edward McHugh, Sr. Rose Le			
6	NOTE, INALYIGHG Z.  ges 1 and 2 should be filed in to Health and Mental Hygie  if item 27 is marked other:  or other treumatic event, the		19a. Informant's Name/Relationship (Type, Print)  Mary Wolf/Daughter  19b. Mailing Address (Street and Number or Ru 1004 Gunridge Cir			
			20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - City or To	
응	Page Page nent o ant: if		1 □ Burial 2 XCremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Metro Crematory, Inc. 8	3/14/06	Baltimore	. MD
当意	Saltimore, bernit, Pages 1 ar Department of Hea Important: If Item any injury or othe		21. Signature of Funeral Service Licensee C. Todd Dring Cremation Socie	ty of h	Maryland,	Inc.
$\omega$			299 Frederick R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	d Balt.	Lmore, MD	21228
	Dhualaina		shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):			wough
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V	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last			
700	te be e ysicien	cal	d			
9	rifficat ng phy	Medi	IF FEMALE:			
$\neg$	ath cer attendin or use	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delive Month	ary Day Year
$\mathcal{G}$	UIVISION OF VITAL RECORDS, P.O. BOX 68/60, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown			,
<u>ر</u> کر ا	S, T se that so that produced be detailed	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
4	ecords law requires as been sign	ted	AGI, CAD	1 🗆 Yı	es 2 🗖 No 3 🗆 Prob	ably 4 Unknown
$V_{\mathcal{Q}}$	4eC	Completed		24a. Was a autops perfor	y prior to co	psy findings available mpletion of cause of
	VITAL F	e Co	OF Was area referred to disclaim	1 Tes	2 No 1 □ Yes	2 No
	OT VITA Physician: rthis certifice ral director,	0 0	examiner?	ath (Check only on	ence 6 ⊡Other (Specif	iel
	n OT ng Phy ter this	n: T	27. Mannerof Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?		ow injury occurred	7/
6	SIOI tsndir leath. tor: Af the fu	catic	2 Accident investigation M 1 Yes 2 No			
Ď.	JIVISION  I or Attending after death.  Director: After in by the fune	Certification:	4 Homicide determined determined determined determined determined building, etc. (Specify)	28f. Location (S. City or Town	treet and Number or Rura n, State)	Il Route Number,
\$\frac{1}{2}	DIVISION  To the Hospitel or Attending I within 24 hours after death.  To the Funeral Director: Attention of the Funeral Director Attention of the funeral Director of the fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	, and due to the c	ause(s) and manner as s	tated.
1	To the Howithin 24 To the Fuctor	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			
	No Con	~	29b. Signature and title of certifier  29c. License number  D 7 3 1 (5)	2	9d. Date signed (Month,	Day, Year) 20 (
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	
	4		Jeff londrow for walth Bled Carball	e mo	21234	
	Sta Regist		31. Date filed (Month, Day, Year)  32. Rigistrar's Signature			
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		1 - For State Reg	e istrar			State o	f Mar	yland			nt of H			lental F	lygien Reg. N		)6	2552	9
	siciar	7	ent's Name		e, Last)					/	BAK	ER		2. Date of Month	D		Year	3. Time of Death 16:56 Pt	м
	edica mine	4a. Facilit	JOHNS Security Nur	topic Hopi		1.0	PITAL	(In yrs. las	st birthday)	R4	Town, or	10RE	C1 T	8. Date of	4 Birth	c. County o	Death  9. Birthp	lace (State or Foreig	gn
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d be filed wit	á	17. Fathe	or's Name (F	irst, Middle,		5+			Assis	stant	Dire	18. Moth	ner's Name	e (First, Mid	dle, Maide	ucati en Sumame			
, Märyl end 2 shout telth and Me or traumati	ţ	19a. Info	emy J.	ne/Relations	hip <i>(Typ</i>	_	nd		2807	Nort	h Gle	and Numb	er or Rur	al Route Nui #873	mber, City				
baltimore, permit. Peges 1 en Depertment of Heel important: if item 2		10	hod of Dispo Burial 2 X Donation 5 ature of Fund	Cremation Other (S	pecify)		State		ce of Disponetery, crea	emato	ry	A	Aug.	12, 06	6 Bal	Location - C	e M	D	
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icate be executed physicien and sine burial-transit	Evaluation	resulting	ially list conc ading to imm Enter Underly Disease or in Ited events in death) La		c.	FUA	(or as a ) GA (or as a	conseque	いと ince of):									6 WEEK	
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OrdS requires een sign	Ì	Part II. O	ther signific	ant condition	ons cont	ributing to d	leath but	not result	ing in the u	nderlying	cause give	en in Part	I. 			2.DE(No :	B Prob	e cause of death?  ably 4 □Unknow	
The The ete h			case referre	d to medica								26 Place	e of Deat	24a. W au pe 1 Ye	utopsy erformed? s 2	de	ath?	osy findings availab npletion of cause of	le
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UIVISION To the Hospitel or Attending Within 24 hours efter death. To the Funeral Director: Attent	orditordian.	3   4	Accident Suicide Homicide	6 □ Could determ	not be	build	ing, etc.	(Specify)	ne, farm, st	reet, facto	ry, office			City or	Town, Sta	ite)		l Route Number,	
To the Hospitel or within 24 hours of To the Funeral Dominately filled in	COLON		eck only 2	Medical	Examin	er: On the b	e best of pasis of e aner state	xaminatio	ledge, deat on and/or in	vestigatio	at the time, in my open	pinion, de	ind place, lath occurr	and due to t red at the tin	ne, date a	(s) and man nd place, ar Date signed	nd due to	the cause(s)	
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			For State Registrar	State of Maryla		artment of H		Mental Hy	/giene	2006	25530
	Dhusisi		1. Decedent's Name (First, Middle, Last,					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		James G.		wning	,		AUGUST	12	2006	3:47AM
	Examir	er	4a. Facility Name (If not institution, give				r Location of Dear		4c. C	ounty of Death	
			5. Social Security Number 6. Sec		rs. last birthday)	BATUIN If Under 1 Year		<b>b</b>	ieth	O Risth	olana (Stata or Foreign
	Funeral Director			M 2□F 55	Yrs.	Months Days	Hours Min		ay, Year)		place (State or Foreign htry) SSOUT1
			Usuat Residence of Decedent					oune 1	190	ı Plı	SSOULT
	ehow	_	10a. State 10b. County	10c.	City, Town or Lo	ocation				1	Od. Inside City Limits
	8 -1 8	Director	MD Balti	more		Reiste	rstown				1 ☐ Yes 2 ☑ No
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JAMES 21215-	hen "	ig.	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retired	,	9			
14 2	fygier fygier her ti		17. Father's Name (First, Middle, Last)	4	Tea	m Leade:		me (First, Middle		1 Secur	ity Adm.
R /lanc	od of	Be	James	R. Browni	ina		_	me <i>(Fir</i> st, <i>Middle</i> eanne	Stins	,	
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દ્દાવેઓ e, Mar	od 2 sulth ar		Grace Browning	Wife		Dunholme		eisterst			
Je j	s 1 er f Hea ttern othe		20a. Method of Disposition		. Place of Dispo	sition (Name of matory or other place		Date		tion - City or To	
Philast altimo	Page nent o nt: If ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	-	remation	1	14/06	Hamp	stead,	MD
Philade followly As JAMES Ba. Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then may highty or other traumatic event. It is MDE.		21. Signature of Funeral Service Licens			2. Name and Addre		11824 Re			
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			JALL ASCULA	1 0.42				1 DM
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Вох	leath certifica attending ph I for use as th	an/N	230. Was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23	d. Date of delive	•
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₹	Physicien: this certificaral director, p	To Be	avaminar?	lospital: 1 Inpatient 2	□ EP/Outpation	ot all DOA Oth		ath <i>(Ch</i> eck only dome 5 ☐ Res		70th-1/0	
o o	g Phy er this eral c		27. Manner of Death	28a. Date of Injury (Month, Day Year)		" 3D DON	4   Haramy I	28d. Describe			/)
Ö	ath. r: After	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Fear)	) Injury		k? Yes 2∐No				
Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location	(Street and I wn, State)	Vumber or Rura	l Route Number,
Ō	ital or irs afte ret Dir lled in										
(10)	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) ar date and pl	nd manner as si ace, and due to	ated. the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and mailler Stated.		29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
	70			61 D.O.		RE	s 000			F12,	,. ,
	10		30. Name and address of person who co		tem 23a) (Type.	Print)					
	10		TEREMY M. INFF. D.				2401 W.	Belvenere	NE. I	Browne	MO 21215

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 5 2006

THOMAS BLAIR

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artment of F		-	giene Reg. No. 200	25531
ı	Physici		1. Decedent's Name (First, Middle, La Thomas B. Blair	st)				2. Date of De Month August	Day Year 11,2006	3. Time of Death 8:20 P. M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			r Location of Death		4c. County of De	ath
+	Funeral		Stella Maris Hosp 5. Social Security Number 6.5	Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year	nonium If Under 24 Hrs.	8. Date of Birt	h O.B	re County inthplace (State or Foreign
Ī,	Director		162-22-8840 Usual Residence of Oecedent	18 M 2□F 78	Yrs.	Months Days	Hours Min.	(Month, Da Sept. 0	2,1927 Li	sbon,Ohio
	Maryland -f ehow	tor	10a. State 10b. County		ity, Town or Lo aldwin	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code	-		10g. Citizen ol What 0	Country?
	eath w	erai	3203 Wellington W	ay 12. Was Decedent Ever in	U.S. 13		1013 Iispanic Origin? (Sc	pecify Yes or No.	United St	
020	ours after d al', or item Exeminer.	þ	1 Never Married 2 Married  3 ₩ Widowed 4 Divorced	Armed Forces?		If Yes, specify Cubin	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		
0-617	vithin 72 ho ne. hen "natur e Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give		during most of world)	king	16b. Kind of Busines	
מנומ ע	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelih and Mental Hygiene. If the eith and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other treumatic event, the Madical Examiner must be notified at	To Be Cor	12 17. Father's Name (First, Middle, Last Raymond Clide Bla		2	Stock Bro			Investmen	t Balking
Mary	nd 2 shoul sith and Me 27 ie mark r treumati	ř	19a. Inlormant's Name/Relationship (						er, City or Town, State, , Maryland	
altillore,	permit. Pages 1 and Department of Heeli importent: if item 2 eny injury or other once.		20a. Method of Disposition  12 Surial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special	Removal from State	cemetery, crei	osition (Name of matory or other place Valley Mei	~ Cab 1149	06	20c. Location - City of Timonium, M.	
Dall	permit. Departmimporte eny inju		21. Signature of Funeral Service Lice	7. your,	DIL PE	125 Vork 1	ss of Facility lternativ	es Fune:	ral&Cremat	ion Ctr.,P.A. 21093
	Physician /Medical Examiner		23a. Pa/1/Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. LIVER DISE.  Due to (or as a conse	ASE equence ol):	er the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
,00700	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be deteched for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse						
O. BOX 0	w requires thet the death certifics been signed by the attending pt should be deteched for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
cords, r	quires thet an signed b	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 X Unknown
ב	The ate h page	Completed			19 000 6			24a. Was autop perfo 1 ☐ Yes	rmed? death?	autopsy findings available completion of cause of
N I G	sician: certific lirector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatier	oth 30 ma Oth	26. Place of Deat	121	7/7	ecify) HOSPICE
5	• = @	-	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur			now injury occurred	ecily) HOSPICE
	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funeri	Certification;	3 Suicide 6 Could not be determined		home, larm, str sify)	reet, lactory, office		28l. Location (S City or Tox	Street and Number or I vn, State)	Rural Route Number,
	ne Hospil n 24 hour ne Funer	edicai	29a. Certifier (Check only one) (Check only one) (Check only one)	nysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To t To tl	Ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mor	
•	27		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,		125		8/14/0	16
1	7"		DR. TARIQ MAHMOO	D 2300 DULAN	EY VALL	EY RD. 7	TIMONIUM,	MD 2109	93	
	Sta Registr	_	AUG 15	32. Fegistrar's Sign	B. A	per				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fft 2865 3 22 07 yt.
State 5 Maryland 2 be annient of Health and Mental Hygiene

			For State Registrar	State of Marylan		artmént of H rtificate of L			ne No2005	25532
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		JANE MARSHALL	BAIRD					2, 2006	7.30 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Death	, , , , , , , ,
			BROADMEAD			Cockeys	sville		Baltimore	County
	Funeral		5. Social Security Number 6. Sex 1057-38-1384		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthy	place (State or Foreign
	Director		089-09-9780	M 21XF 98	Yrs.	WOITE Days	Tiodis Wiii.	March 18	. 1908 Was	shington,DC
	9		Usual Residence of Decedent	T						
	rylar how	_	10a. State 10b. County	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	Ma -	cto	Manual Baltimore	County	Cocl	keysville				1 ☐ Yes 2 🔀 No
	다 다 9r 28	Director	Maryland   Darelliote 10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry?
	th wi	air	13801 York Road			210	030		USA	
	dea	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spon. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	a within 72 hours after death with the Maryland Jiene. r than "natural", or itema 23a or 28a-f ehow Tha Mazical Examinar musi ke notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify: Wh	
21215-0036	2 hour		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation	168	o. Kind of Business/In	
75	nin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work  )	ng		
2	d within giene. r than "	mo	Listing Raty/Good Idaily (6 12)	4	Hon	nemaker			Own Reside	ence
ਰੂ	illed Hygi other	ВеС	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Mai	den Sumame)	
Maryland	s 1 and 2 should be filer f Health and Mental Hyg Item 27 is marked othe other traumatic event,	To E	Thomas Worth Mar	sha11			Kathle	en	Huff	
ary	2 should I and Meni is marke		19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street a			ity or Town, State, Zip	Code)
Ξ	1 and 2 Health a sem 27 is		Mary Jane Milner	(Daughter)	234	Westwood	Road And	napolis.	Maryland	21401
ē,	S 1 a f He f ftem othe		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place			. Localion - City or To	own, State
6			1 ☐ Burial 2 【 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	unt Crema		/2006 B	altimore.	Maryl and
altimore,	그 분 뿐 글		21. Signatury Print al Servin Alternation	9711-171	2	2. Name and Addres	ss of Facility	/2000 I	arcimore,	riaryrand
ä	permi Depa Impo any ir		Martin D. Laws	on	I N	Mitchell-W	Viedefeld	Funeral 1	Home, Inc.	1212
			23a. Part 1. Enter the disease, or compli	cations that caused the deat	n. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arrest,	maryiand 2	Approximate Interval Between
			Immediate Cause (Final	e cause on each line.	アカハ	V C				Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	vence of:	SE				
п	Examiner			240 10 (01 43 4 0011004	001100 017.					
	-	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
	Bold In	m in	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ć,	tificate be executed go physician and as the burial-transit	Examine	resulting in death) Last	Due to (or as a conseq	uence of):					
68760	e be rsicia e bur									_
68	ificat g phy as th	edical								
Вох	eath certiff attending for use as	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d. Date of delive	ery
m	death atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.O.	that the denet by the a	Physician/M	9 Unknown	9□Unknown						447
	The law requires that the death certi tte has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
of Vital Records,	quires n sign		JAD					1 ☐ Yes	2 1 No 3 □ Prot	oably 4 Unknown
00	w requir been si should	Completed	DVD					24a. Was an	24b. Were auto	opsy findings available
Re	The law	m d						autopsy performed	prior to co death?	mpletion of cause of
a			as Manager de la diset					1 ☐ Yes 2 Д	Mo 1□Yes	2∐ No
₹		Be	25. Was case referred to medical examiner?	ospital:	50:0	other actions of the		(Check only one)	• 50 to 10	
of	Phys this ral di	- To	1 Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie 28b. Time of	III 3 DOA	41 Zimidi Sing no	me 5 Hesidenc 28d. Describe how	e 6 ⊡Other (Specification of the following of the follow	y)
	ding After fune	ion	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Worl	k? Yes 2□No		,,	
S	Attending ir death. ector: After by the fune	ica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm st		-	28f. Location (Stree	at and Number or Rura	al Route Number.
Division	l or Attendation after death	Certification:	4 Homicide determined	building, etc. (Specif	y)	index, radioty, emission		City or Town, S		
	apita lours neral		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, dea	th occurred at the tin	ne, date and place,	and due to the caus	e(s) and manner as s	tated.
	To the Hospital within 24 hours of the Funeral completely filled	edicai	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	tion and/or ir	nvestigation, in my o	pinion, death occuri	ed at the time, date	and place, and due to	o the cause(s)
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Me	29b. Signature and title of certifier	1		29c. Licenso	e number	29d.	Date signed (Month,	Day, Year)
			Brankensa	(ASSALL	1/2	AD:	3839-	2	8/14/-	2006
	12		30. Name and address of person who co	mpteted cause of death (Item	n 23a) (Type	, Print)		)	/	/ 1 1
	10		BARBARA CA	RROLL, M	D. 1-	3801 VI	ork Ro	1, Cock	LUSVILL	(M)
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	W)		1		1
	Regist		AUG 1 5 2006	Sulvey 15	12 mg				~	

Jane Bail 8-12-06

			For State Registrar	State of Maryla		rtment of Heal			ene) () () ()	25533
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	G.B	veita	en bac	& 2	Date of Death Month	Day Hh Zoar	3. Time of Death
	Examin Funeral	y	4a. Facility Name (If not institution, give		N.H. s. last birthday)		ug vil li	Date of Birth Month, Day, 1	4c. County of Death	nplace (State or Foreign
	Director		222 30 1,20	M 2√2 F 95	Yrs.	Months Days Ho	Ja	n 17,	1911 Mary	land
	and and the same of the same o		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits
	Maryl Ind	tor	MD Baltimore	Ar	butus					1 ☐ Yes 2⁄☐ No
	with the 3a or 28a	I Director	10e. Street and Number 925 Grovehill Road			10f. Zip Code 21227			g. Citizen of What Co	untry?
936	is 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	j,	Vas Decedent of Hispar Yes, specify Cuban, Mi	nic Origin? (Specify lexican, Puerto Rica pecify:	Yes or No- n, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
21	within 72 ho iene. than "natur na Medical	Completed	15. Decedent's Edd (Specify only highest grad		(Give	lent's Usual Occupation kind of work done during OO NOT use retired)	g most of working		6b. Kind of Business/	ndustry
Maryland 21	buld be filed wental Hygie arked other atte event, tr	Be	17. Father's Name (First, Middle, Last) John Stein		10000		Mother's Name (Fin	st, Middle, M		
aryl	2 should and Men is marke aumatic	2	19a. Informant's Name/Relationship (T)	/pe, Print)	19b. Mailin	g Address (Street and f	Number or Rural Ro	ute Number,	City or Town, State, Z	lip Code)
	ss 1 end 2 of Health a ltem 27 is r other tra		Eleanor C. Breiten			Grovehill R		-		
Baltimore,	Pages 1 nent of H ant: If Ite	3	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  4 □ Domation 5 □ Other (Specify)	Removal from State		sition ( <i>Name</i> or natory or other place) nrk Cemeter	y 8-14-20		oc.Location-City or altimore,	
Balt	permit. Pages Department of Important: If It any injury or once.		21. Sonature of Funeral Saving Licens	Youat	Ar 13	Name and Address of 1870se Fune 128 Sulphur	ral Home, Spring R	Inc. d. Arb	utus MD 21	.227
	Physician		23a. Part 1. Enter the disease, o comp shock, or heart failure. List only o tmmediate Cause (Final disease or condition	lications that caused the dene cause on each line.	Do not end	er the mode of dying, su	uch as cardiac or res	spiratory arres	st,	Approximate Interval Belween Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					7
V	pe is:	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Classes or injury	b. Due to (or as a cons	sequence of):					
. 1092	ate be executed hysicien and he burial-transit	cal Examiner	that initiated events resulting in death) Last	C. Due to (or as a cons	equence of):					
O. Box 68	ne death certific the ettending p thed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 [	Ectopic pregnancy Other (specify)			23d. Dale of del Month	ivery Day Year
ds, P.	Se 050	ρ	Part II. Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause given in	n Part I.		acco use contribute to s 2 □ No 3 □ Pr	the cause of death?
Vital Records,	e law has b	Completed						24a. Was an autopsy perform	200. Were au prior to death?	topsy findings available completion of oduse of
/ita	itor,	Be	25. Was case referred to medical examiner?	He seital:			. Place of Death (C	heck o <i>nly</i> one	)	
of	Phys r this ral di	. To	1 Tes 2000	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year					nce 6 Other (Spe w injury occurred	cify)
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation		) Injury		2  No			
Division	el or Attendi s after death. Il Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	I home, farm, sti ecify)	eet, factory, office	281.	Location (Str City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		sician: To the best of my liner: Onthe basis of examiner and manner slated.						
	To th withir To th	Me	29b. Signature and title of certifier	Jano	l	29c. License nu	192	6 6	d. Date signed (Mont	7. Day, Year)
	3		30. Name and address of person who d	completed (a) so onde and (	tem 23a) (Type,	M-3450	9 StA	this	Jane SII	icotto inco
100 x	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 15 2	32. Redistrar's Si	gnature	facele	, ,()		_	

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		Cer	rtificate of	Death			Reg. No.	France	UUU	2000	
	Physici	an/	Decedent's Name (First, Midd		2. Date of D	eath			Time of Death					
/ledi	cal Exami	iner	Charles Wilford	l Beasley					Month August	Day 6, 2006	Yea	1	1940 hrs	
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of I  Bon Secours Hospital  Baltimore							40	County o	f Death		
	Funeral		5. Social Security Number	ast birthday)	If Under 1 Year	If Under 24H	rs. 8. Date of	Birth (MM/		9 Birthpla	ce (State or			
	Director		227-40-4169	1XM 2F	70	Yrs.	Months Days	Hours M	Sep.	27,	1935	Foreign Country	v) VA	
	è		Usual Residence of Decedent  10a State 10b. County		Inc. City	Town or Location	20					1104	Inside City Limits	
	, w		,	37 / A	Toc. City,			o City					X Yes 2 No	
	daryland 28a-f show any <u>1 at once.</u>	ţ	MD	N/A			Baltimor	e City						
	Mary 28a	Director	10e. Street and Number				10f. Zip Code			10g Citi		at Country?		
	ith the Maryland 23a or 28a-f sho notified at once.		350 South Call	noun Stre	et			21223			Uni	ted S	tates	
	h wit ems 2 t be n	era	11. Marital Status  1 Never Married 2 M		ecedent Ever in U. Forces?		s Decedent of Hisp es, specify Cuban,			No-	14. Race White		Indian, Black,	
	r deat or it	Funeral		1X Yes	2 No			10 1110411, 010.7			Whit	e		
	s afte ral", niner	by	3 Widowed 4 X Div	orced If Yes, Give Y	@952-195			X No specify				Specify:  6b. Kind of Business/Industry		
	hour matu Exar	ted	Elementary/Secondary (0-12)		(1-4 or 5+)		's Usual Occupations of working life.			100.1	(ind of Bus	siness/indus	stry	
30	5-0030 led within 72 hours after Hygiene other than "natural", the Medical Examiner	Complete	6	College	(1-40/51)		Carpente	r			Cor	struc	struction	
Č	d with	ě	17. Father's Name (First, Middle,	Last)					ne (First, Middle	e, Maiden	Surname)			
24245 0025	Z 1 Z 1 D-0030  uld be filed within 72 hours a Mental Hygiene marked other than "natura e event, the Medical Examir	- a. I	Agge Beasley					Cathe	erine Ta	ipsco	tt			
	III Z 1 Z 1 2-1030 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-fish matic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (Street					, State, Zip	Code)	
2	Sho		Margaret Weave	er - Sist	er	350	South C	a1houn	Street,	Ba1	timor	e, MD	21223	
9	Fe, land		20a. Method of Disposition  1 XBurial 2 Cremation	2 🗆 🗆			tion (Name of cem		Date	20c	Location - City or Town, State			
8	Pages ent of			fis¹°Cemet∙ 11e	8-15-2006   Crownsville,					MD				
3	Agge Beasley  Cather  To be a light of the l									inera	1 Hon	ie. In	1C.	
٥	0 89 11	1	Call une	Arbu	tus,	MD 21	227							
	Physician		23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line										oproximate Interval etween Onset and	
	/Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease complicated by Environmental Hyperthermia									Death		
			or condition resulting in death)	Due to (or as	a consequence o	f):								
		-i	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence o	f)·						_		
	_	i E	cause Enter Underlying Cause (Disease or injury that initiated	C										
J	uted td ransit	Examiner	events resulting in death) Last	Due to (or as	s a consequence o	f).								
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ď	as a si	ian	23b. Was decedent pregnant in the past 12 months?	LIVE	e birth gnant at time of de	ath	al death 3	Ectopic preg	nancy		Month	Day	Year	
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	s that the death certined by the attending detached for use a		Part II. Other significant condit	ions contributing	to death but not re	esulting in the u	nderlying cause giv	ven in Part I	23e. Dic	tobacco	use contrib	oute to the ca	ause of death?	
0	ires that signed b	d by							1 _ Y	es 2	No 3	Probably	4 🗸 Unknown	
5	rds, requir been s	Completed							24a. Wa				findings available	
Ģ	e law e has ge 2 sh	ם			-			<del></del>	per	opsy formed?	de	eath?	etion of cause of	
ò	tal Rec tian: The l certificate l ector, page											2 No		
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4	TOL VI	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b. Time of Ir		at Work?	28d Describ					
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ë	pital or At ours after derail Direction by	erti		annian a d	y) Single Fan	nily Home			or Town 350 South	State)	un Stree	t, Baltimo	ore. MD	
	Hosp 24 ho Fune rtely f			hysician: To the b					nd due to the ca	iuse(s) an	d manner a	as started		
	To the Hos within 24 h To the Fun completely	Medical	2 Medical Exa	miner:On the basi and manne	s of examination a	nd/or investigati	on, in my opinion,	death occurred	d at the time, da	te and pla	ice, and du	e to the cau	ise(s)	
	F > F ō	ž	296. Signature and title of certifie				29c License	number		29d	Date signe	d (Month, D	Day, Year)	
			1 Carn Vent	2111			O.C.N	1.E.		Aug	ust 7, 2	006		
	121	1	Name in address person								1			
	1			ssistant Medic			Street, Baltim	ore, MD 21	201					
	S Regis	tate trar	31. Date filed (Month, Day, Year),	2006	Registrar's Signati	L'OSA	V							
		1121	1100		_	V /	_							

Please Type or Print in Black Indelible Ink Roderick Burnett State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day August 11, 2006 **Medical Examiner** oderick 0610 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2415 Greenmount Avenue Apartment 3 Raitimore N 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Foreign Director -10-1983 213-04-8168 1 X M Country) Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits Yes 2 hours after death with the Maryland Director 10g Citizen of What Country Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes 1 Yes 2 No specify Divorced If Yes, Give Year and Mental Hygiene
7 is marked other than "natural", <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) arham Koderick 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E.25th St. Burnett-mother Balto, 1645 Rralde 20a Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 VBurial 2 Cremation 3 Removal from State New Cathedral Donation 5 Qther Specify 22. Name and Address of Facility FredHILTON Fan P. march Funeral Home 1to, md, 21229 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** List only one cause on each line Between Onset and /Medical Alcohol and fentanyl intoxication Death Immedial- Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical X UNPENDED burial AMENDED iter#23a.27.28a-f.perME...858.8/29/06 TT Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23d Date of delivery Fetal death 3 Ectopic pregnancy Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available autopsy performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical Division of Vital 26 Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 DOA ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Pending Fnd 8/11/2006 Fnd 5:50 am unk Investigation 28f. Location (Street and Number or Rural Route Number, City or Jown, State). 2415 Greenmount Ave Apt 3 Baltimore, 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide determined (Specify) Found at residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

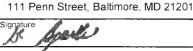
31. Date filed (Month, Day, Year)

Ling Li, MD

State Registrar

29b Signature and title of certifier

37. Registrar's Signature



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 11, 2006

, mis 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Helen <u>12:</u>10₽<sup>™</sup> Becker August 12, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 420 Oak Grove Road Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 186-01-1889 102 Yrs Director March 3,1904 PA Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelih and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, the Madical Examiner could be inclified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes X No Director Anne Arundel Linthicum 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 420 Oak Grove Road 21090 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No White Specify. Completed by If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Bruce Galloway Georgie Marr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Beach Road Arnold MD 21012 Mr. Robert Becker / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 15, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 4 Donation 5 Other (Specify) 2006 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYUCARDIAL INIZRACTIONI 1+000 /Medical Due to (or as a consequence of): Examiner CAMPIOURSCULA + MINUSCI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed igned by the ettending physicien and be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 I Inknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1□ Yes 212 No of Vital 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Atter thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending within 24 hours after deeth.

To the Funeral Director: A completely tilled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide To the Hospital Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JIS CAMP MEMOF avan 0 JOIMISHAMENS 17. egistrar's Signature 31. Date filed (Month, Day, Year) 32 State AUG 1 5 2006 Registrar

		·	For State Registrar	State of Maryland		epartment of Ho Certificate of L			giene ( Reg. No.	2006	25537
	Physici /Medic		Decedent's Name (First, Middle, Las.)	Margie Ann Br	yan	t		2. Date of De. Month	Day	200	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, give 15. Social Security Number 16. Security Number 11. 42. 9626	ral Hispital		4b. City, Town, or  4b. City, Town, or  4day) If Under 1 Year  Months Days	Mocation of Death Mocation If Under 24 Hrs. Hours Min.	8. Date of Bird Month, Da Oct. 8,	4c. C	N/A  9. Birt	h hplace (State or Foreign unity) cth Carolina
	D.		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town	or Location		000.0,			10d. Inside City Limits
	a-f eh	ctor	Maryland N/A	B	alti	imore					1 A Yes 2 □ No
	an or 28	i Directo	10e. Street and Number 2840 Georgetown	n Road		10f. Zip Code 212	30			on of What Co .S.	untry?
036	hin 72 hours after deeth with the Maryland B "natural", or Iteme 23a or 28a-f ehow Medical Examiner must be neilified at	by Funerai	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	3.	13. Was Decedent of Hi If Yes, specify Cubar		ecity Yes or No Rican, etc.)		Race - Ame Black, Whit Specify: Wh	e, etc.
1215-0036	within 72 ho ene. then "naturi he Medical I	Completed	15. Decedent's Ed (Specify only highest grad	cation de completed) College (1-4or 5+)	(	Decedent's Usual Occupa Give kind of work done d life. DO NOT use retired; nitress	ition uring most of worki	ing		of Business/ aurant	Industry
yland 2	be tiled tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)	am Stone			18. Mother's Name	e (First, Middle, Holt			
Maryi	should and Men is marke	To	19a. Informant's Name/Relationship (7		19b. I	Mailing Address (Street a			er, City or	Town, State, 2	Zip Code)
	s 1 and 2 shou f Health and M Item 27 is mar other traumat		Mary Winebarger			O Georgetow		Baltimo		Maryla:	nd 21230
Baltimore,	0 = 5		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			Disposition ( <i>Name of</i> , crematory or other place ivet Cemeter					Maryland
Balt	permit. Peg Depertment Importent: any Injury o		21. Signature of Furneral Service License	Oredas		22. Name and Addres					ce, P.A. land 21225
			23a. Part1. Enter the disease, or compshock, or heart failure. List only of	lications that caused he death one cause on each line.	. Do no	0		or respiratory ai	rest,		Approximate interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. HSPirotio  Due to (or as a consequ		Preumon	10				
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as consequ	ence of	er					
og,	ficate be executed physicien and is the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of	<b>(</b> ):					
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2	w requires thet the de been signed by the a should be detached f	ρ	Part II. Other significant conditions or	ontributing to death but not resu	Iting in	the underlying cause give	on in Part I.		obacco use		the cause of death?
Vital Records,		Completed						24a. Was autor perfo 1 □ Yes	osy rmed?	prior to death?	itopsy findings available completion of cause of 2 ☐ No
\ \ \ \	ysician: Th is certificete director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Thipatient 2	ER/Out	patient 3□ DOA Othe	26. Place of Death			Other /Soa	cifu)
Division of	ding Ph .r After th funeral	$\vdash$	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Ti	me of 28c. Injury		28d. Describe			ony)
DIVIS	al or Attendes setter destination of Director;	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farr	m, street, factory, office		28f. Location (. City or Tox	Street and wn, State)	Number or Ru	ural Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by	edical		ysician: To the best of my knowiner: On the basis of examinat and manner stated.							
	To th within To th comp	Ň	29b. Signature and title of certifier	A. Hayras M.	<b>'</b>	29c. License	number E 7 Q		29d. Date	signed (Mont	h, Day, Year)
	1		30. Name and address of person who			Type, Print)	510		Hug	UST 10	1,2006
	9		Saad A.	tagras M.D.	C	le Marylar	nd Gen	eral t	lospi	tal	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 5 200	37 Aegistrar's Signal	?	Coule			1		

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

			T = State Registrar			Ce	ertificat	te of i	Death		F	Reg. No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Las SEYMOU	•			BOND				Date of Dea		0)6681	3. Time of Death 1:25 P м
	Examin		4a. Facility Name (If not institution, give HOSPICE OF BALTIM			CTR.			Location o	SON				ΓIMORE
	Funeral Director			9X ▼ M 2□ F	7. Age (In yrs	last birthday Yrs.	Months	r 1 Year Days	If Under a	Min. 8	Date of Birt	71916	9. Births	place (State or Foreign htry) MD
	and *		Usuel Residence of Decedent  10a, State 10b, County		10c. C	ity, Town or I	ocation						1	0d. Inside City Limits
	e Maryla 3e-f eho	Director	MD BALTIM	ORE			TIMOR	E						1 □ Yes 2 🏋 No
	h with th		7 SUDBROOK LANE				10f. Zi	p Code	2120	8		10g. Citizen of	What Cour	usA
980	within 72 hours after death with the Maryland iene. r than "natural", or lleme 23a or 28e-1 ehow the Modical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Dece Amed For 1 A Yes If Yes, Giv Year or Da	rces? 2 ∐ No e	U.S. 13	. Was Dece If Yes, spe 1 \(\superset\) Yes		ispanic Origin, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. Ra Bla Spec	ce - Americ ack, White,	ean Indian, etc. WHITE
9	2 ho	ted	15. Decedent's Ed	ucation		16a. Dec	edent's Usu	al Occup	ation	of working		16b. Kind of I	Business/In	dustry
21215-0036	within ene. then "	Completed	(Specify only highest grad	College (1	-4or 5+)	life.	CHER	ise retired	during most 1)	or working		MEAT (	CUTTER	₹
Maryland 2	should be filed nd Mental Hygis marked other umatic event, it	To Be C	17. Father's Name (First, Middle, Last) MORRIS			BON	ID		18. Mothe		First, Middle,	Maiden Suma	me)	ZAKER
	d 2 sho th and 7 is m treum		19a. Informant's Name/Relationship (7 ALAN KAPLAN / NE	,, ,			-					r, City or Town GS MILI		·
Baltimore,	of of or	18	20a. Method of Disposition  1  Burial 2  Coremation 3   4  Donation 5  Other (Specify			Place of Disp cemetery, cri				Dat 8/14/		20c. Location	- City or To	
Baltir	permit. Pag Department Important: eny injury o		21. Signature of Funeral Source Line		111		22. Name a	nd Addre	ss of Facility	y SOL	LEVIN	SON & E	ROS.	
			23a. Part1. Enter the disease, or comp	olications that ca	aused the dea	ath. Do not e							,	Approximate
V.	Physician	0 1	23a. Part1. Enter the disease, of camp shock, or heart tallure. List only disease or condition resulting in death)	one cause on ea		ente	-				*			Interval Between Onset and Death Weeks
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	<u>D</u>		30. Name and address of person white	G-Pm	or death (Ite	3 70 (Type	M-	Chr	ile,	Sti	Bal	to me	1 >	Day, Year) 2006
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 5 201	06 32/R	egistrar's Sign	Table A	selle!							

		•	State of Maryla	•	rtment of Healt tificate of Dea			ene20	06	25539
0	* × 5		Decedent's Name (First, Middle, Last)				2. Date of Death Month			3. Time of Death
	Physicia /Medic		Grace Brown				August	<sup>Day</sup> 20	900	9:00 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Local			4c. County		
		4	Mariner Health of Glen Bur		Glen Bur			Anne		
	Funeral		1 M 2 VF	. last birthday) 92 Yrs.	Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, March 3	1914	9. Birthplac	ce (State or Foreign y) 1and
**	Director		215-24-2260 Usual Residence of Decedent	3 2.			Tal CII	1 7 1 3	Hary	Tana
6	MON THE			ity, Town or Loc	ation				100	d. Inside City Limits
2	Tied Die	ğΪ	Maryland Anne Arundel	Severna	a Park					1 ☐ Yes 2½ No
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3	atura		15. Decedent's Education	16a. Deced	ent's Usual Occupation	most of works		6b. Kind of Bu	siness/Indu	istry
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-	4 4 5 6		19a. Informant's Name/Relationship (Type, Print) Luvinia Coates (Daughter)		g Address (Sireel and N B & A Blvc					
	Health Health tem 27				sition (Name of natory or other place)			Oc. Location -		
ğ	rages nent of int: If it iry or o				er Hill	8-12	-06	Severn	a Par	rk, Md.
Baltimore,	permit. Pages Department of h Important: If ite ony injury or of		21. Signature of Funeral Service Licensee		Name and Address of	Facility	Mortua	erv. P	Δ	
ñ		6 8	Lavry & Beese MOS48	_	21 West St					1
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<u>≥</u>	after after Dire	Certification:	4 Homicide determined building, etc. (Spe		•		City or Towr	i, State)		
	To the Hospital or Attending in within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  Certifying Physicien: To the best of my keep control of the basis of examiner: On the basis of examiner and manner stated.	nowledge, deati	h occurred at the time, do vestigation, in my opinion	ate and place, n, death occur	and due to the ca	ause(s) and ma ate and place,	inner as sta and due to	ated. the cause(s)
	within 2 To the I	Me	29b. Signature and title of certifier		29c. License nun	nber	:2	9d. Date signe	d (Month, E	Day, Year)
	7		1 Charles 2 1-	MD	Doz	519	1	tua 1	1 2	2006
•	1		30. Name and address of person who completed cause of death (I	tem 23a) (Type,	Print)	1	0		M	, , , ,
/	1		RICHANDEFISHER MD	CRA	DOE Print) TOWER	5 66	EN DU.	ZNIE	1/1	21061
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			Registrar	41		Cel	tificate	OIL	<i>yeatn</i>		2. Dale of Dea	Reg. No.	000		
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	Funeral		5. Social Security Number 6. Se		Age (In yrs.	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da			place (State or F	oreign
	Director		213-32-5832	□ M <b>X</b> M □		74 Yrs.	Months	Days	Hours	Min.	Dec 8	1931		yland	
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	cation							10d. Inside City	Limits
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<u> </u>	uld be Menta irked ific ev	To B	George Bland						Virg	gini	a Bake	er			
a	2 should be filed within 72 hours after death with the Maryland and Mentel Hygiane. and Mentel Hygiane. It is marked other than "naturel", or items 23s or 28s-f show eumatic event, the Madical Examiner must be notified.		19a. Informant's Name/Relationship (7				•					-	own, State, Zij		
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5	in of the state of		20a. Method of Disposition  1 Burial 2 Cremation 3			lace of Dispo				8-10			ition - City or T		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygians. Dispartment of Health and Mental Hygians. Infortant: It ferm 27 is marked other than "naturel", or items 23a or 28a-f ehow any injury or other treumatic event. In a Madical Examinar must be nutified at once.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen			moria.							polis	, Ma.	
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- 25	, fi		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caus	sed the death	n. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ai	rest,	214	Approximate Interval Betwe	
ı	Physician		Immediate Cause (Final											Onset and De	ath
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ż	Examiner		Sequentially list conditions	b											
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<u> </u>	or At after d Direct in by	Certification:	4 Homicide determined	289. Place of	Injury - Al ho etc. (Specif		eet, factory,	, office		2	28f. Location (5 City or Tox		Number or Rur	al Route Numbe	ď,
-	spital ours sours a seral filled		29a. Certifier 1 Certifying Ph	vsician: To the be	ast of my kno	wledge death	n occurred a	at the time	e date an	nd place, a	and due to the	cause(s) a	nd manner as	stated	
	To the Hospital or Attending Physicien: The law exiting 4 but safer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical Examone)	niner: On the basi and manner	s of examina stated.	tion and/or in	vestigation,	in my op	inion, dea	ath occurre	ed at the time,	date and p	lace, and due t	o the cause(s)	
		Σ	29b. Signature and title of certifier	14			29c.	License	number	C <sub>4</sub>		29d. Date	signed (Month,	Day, Year)	1
	2		P /				C	151	81	1		47	015	1, 200	C
Ì	υ			completed cause of	death (Item	23a) (Type,	Print)	100	CT	5.	vite e	101	Anny	O the cause(s)  Day, Year)  9, 2 0 0	11)
	Sta Registr		AUG 1 5 2	006	Scrar's Signa	S. A.	book	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 tem 20b per fh 9858 8-17-06 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 14 2006 **Physician** 9:30ам Alan K. Clark Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 41 Torque Way Middle River Baltimore Months Days Hours Min. July 31, 1933 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Maryland 1 XM 2 ☐ F 219-30-9821 73 Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No MD Director Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen ot What Country? 41 Torque Way 21220 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1≿□Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lineman BGE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Earl K. Clark Madeline L. Belschner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan K. Clark Jr. /son item 27 616 Wampler Road Baltimore MD 2122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If Ita any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 8-15-06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or periplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastone **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attanding Physician: The law requires thet the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Atter.
ar deeth.
uiractor: After this cer....
'ha funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deeth To the Funeral Director:, completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 024356 August 15, 2006 Weenbey Coren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo

DHMH 17 Rev 1/2001

State

Registrar

WATERPIELD

31. Date filed (Month, Day, Year) AUG 1 5

32. Restrar's Signature

REGIAL

			For State Registrar	State of Marylar	-		t of He			F	Reg. No.	2000	5 25542
	Physicia	n	1. Decedent's Name (First, Middle, Last)							<ol><li>Date of Dea Month</li></ol>	Day	Year	
	/Medic	al	Anna Catherin			4h Cihi	Town, or L	onation of	Dooth	Augus	-	2 200 County of Dea	5 -
	Examin	er	4a. Facility Name (If not institution, give si Gilchrist Cent				ORWC		Death			Ltimo	
	Funeral		5. Social Security Number 6. Sex		last birthday)			If Under 2	24 Hrs.	8. Date of Birt	h	9. Bi	rthplace (State or Foreign Country)
	Director		220-30-6249	M 2⊠F 70	Yrs.	Months	Days	Hours	Min.	Jan.11	, 19:	36 M	aryland
	p 2		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	cation							10d, Inside City Limits
	faryla fahov	٥	MD Baltim		Owings		lls						1 ☐ Yes 2√∑ No
	28a-	rect	10e. Street and Number			10f. Zij					10g. Citiz	en of What C	Country?
	h with	Funeral Director	12495 Greensp	ring Ave.		2	1117				USA	A	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Dece	dent of Hisp	oanic Orig	in? (Spec	cify Yes or No-	- 1-	4. Race - Am Black, Wh	rencan Indian, ite. etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 【No If Yes, Give		1 □ Yes	2 <b>⊠</b> No	Specify:				Specify: W]	hite
Ö	within 72 hours after death with the Maryland ene. Than "nstural", or Items 23a or 28a-f show the Medical Examinar must be motified at	ed b	15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usu	at Occupati	on			16b. Kin	d of Busines	s/Industry
15	nin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of wo	at Occupati ork done du ise retired)	ring most	of workin	g	Tur	f Val	
21.	giene giene er the	Completed	12th		Exec	Juli	ve As					Club	
ng	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last) Edward Frank Hr	chik			1			(First, Middle, B. Mo		Sumame)	
<u>\Z</u>	d Men narke natic	၉	19a. tnformant's Name/Retationship (Typ		10h Maili	na Addras	c /Street an			Route Number		Town State	Zin Code)
Maryland 21215-0036	d 2 st th and th and traur traur		James G. Corne							Ave.			
ē,	f Hear f Hear item 2		20a. Method of Disposition	20b.	Place of Dispo	osition (Na	me of			ate			r Town, State
Ë	Page: nent o int: if iry or		1 ⊠Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State O	Ak Lav	vn Če	emete	ery	8/16	/06	Bal	timo	re MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiens. Department of Health and Mantal Hygiens. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, ira Medical Examinar must be indiffed at once.		21. Signature of Funeral Service License	1 Connel	ly o	Conn		Fun	era]	L Home	of	Esse	lto.MD x 21221
			23a. Part1. Enter the disease, or complice shock, or heert failure. List only on	ations that caused the dea	th. on not en	ter the mo	de of dying,	such as	cardiac oi	respiratory ar	rrest,		Approximate Intervat Between
	Physician		Immediate Cause (Final disease or condition	LUNG C	ANC	ER							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):								
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quantos offr								
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760,	te be executed ysicien and ie burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):								
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× 68	entific ding p	/Mec	IF FEMALE:	3c. If yes, outcome of pregn	ancv					1115		ad Data of d	olivon.
Bo	atten for us	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ XVo	1 Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of	al death 3[	⊒Ectopic p ⊒ Other (s					2	3d. Date of d Month	Day Year
Vital Records, P.O. Box	the d	hysi	9 Unknown	9□ Unknown									
ω̈́.	Physicien: The law requires that the death certifica this certificate has been signed by the attending priral director, page 2 should be detached for use as the	Completed by Physiclan/Med	Part II. Other significant conditions con					in Part I.		23e. Did to	obacco us		to the cause of death?
ord Ord	equire sen si ould b	ted	BRAIN, LIVER	and SPIN	E 110	CIA	DIV	25	2	101	Yes 2□	]No 3□I	Probably 4 Unknown
ě	a law l has b	nple								24a. Was		24b. Were a prior to death?	autopsy findings available completion of cause of
<u>=</u>	n: The icate r. pag									1 ☐ Yes	2 X No	1 🗆 Ye	
Ž	sicier certif irecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ topatient 2 ☐	ER/Outpatie	nt 3□ □	Other	-		(Check only only only only only only only only		Other (Sp	HOSDIC
ō	p Phy er this eral d	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury			8d. Describe I			ischiy) 100   Q
ion	Attending r death.	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day Year)	Injury	М		es 2 🗆 l	No				
Division of	ai or Atte s after de ni Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of tnjury - At h building, etc. (Speci	nome, farm, st	reet, facto	ry, office		2	8f. Location (S City or Tox	Street and wn, State)	Number or i	Rural Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, dear ation and/or in	th occurred nvestigation	d at the time n, in my opi	, date and nion, deat	d place, a th occurre	nd due to the od at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	20.		29	c. License		~		29d. Date	signed (Mo	nth, Day, Year)
	1		Wendallk	+alelle	7		D 35	64	3		08/	13/	9006
	6		30. Name and address of person who co		h 1		ules	01 ~	4/	Ross	~ M	V S	204
	Sta	to	31. Date filed (Month, Dav. Year)	32. Begistrar's Sign			LIES	SUCC	201/	Lywin.	J 1.5	ے د	1001
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 5 200	06 Segues.	B. A.	2646	,						

			1 - For State Registrar		Department of Health and Certificate of Death	d Mental Hygiei Reg.	2000	25543
	Physici		1. Decedent's Name (First, Middle, Last,	CARTE	ER	2. Date of Death	Day Year	3. Time of Death
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give RUXTON HEA) 5. Social Security Number 6. Se 213-36-2033	street and number)	4b. City, Town, or Location of D  PIKES V ILLE  hday) If Under 1 Year   If Under 24 I	8 m	4c. County of Death BALT M 9. Birth arr) 9. Birth	_
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show	Director	Mary Ares i//	BALI	HARRE	100		1 Yes 2 □ No
	th with	ai Dir	2612 Cylbur	N Ave	10f. Zip Code	rog.	Citizen of What Cou	intry ?
980	72 hours after dea natural', or Itema	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Vivorced	12. Was Decedent Ever in U.S. Armed Forces? DEX'es 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	(Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White,	
21215-0036	uges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 Ia marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, the Mardical Examinations to be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b	Kind of Business/Ir	
and 2	be filed stal Hygid of other	Be	17. Father's Name (First, Middle, Last)	/ ^	18. Mother's	Name (First, Middle, Maid		nec ·
Maryland	2 should and Men Is marke sumatic	2	Ruustein B. Chr.		Mailing Address (Street and Number or		ty or Town, State, Zi	
_	Health tem 27 l		KOSALIND E. CAR;	20b. Place of	Disposition (Name of		Location - City or T	
altimore,	Part Tar		1 Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	as a semoval from State	AUN CEMERTY 8	-15-06 WG	DOOLAWA	MARYLAND
Ball	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Service Lickns	ee W.	22. Name and Address of Facility (5240 REISTERSHUE)	Ld Bolton	YARRIVER.	2/2/5-
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final	ications that caused the death. Do n ne cause on each line.	not enter the mode of dying, such as card	diac or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of	of):			
	Examiner	er	Sequentially list conditions if any, leading to immediate	Due to (or as a consequence of	ees when colds.	ipal		· · · · · · · · · · · · · · · · · · ·
-	ecuted and I-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	a fixago	r Hy		
68760,	ficate be executed physician and s the burial-transit	edicai E		t the		0		
P.O. Box 68	deeth certi e attending od for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	ery Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	ntributing to death but not resulting in			co use contribute to t	he cause of death?
of Vital Records,	The law ate has b page 2 st	Completed	/			24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available impletion of cause of
f Vit	ys di	To Be	25. Was case referred to medical examiner?  1 □ Yes □ No □ H	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othor	Death <i>(Check only one)</i> g Home 5 🗆 Residence	6 ☐Other (Specia	fy)
o uo	Attending Pr r death. ector: After th by the funeral		27. Mann → f Death  1 atural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	ime of 28c. Injury at Work?  M 1 Yes 2 \( \subseteq No	28d. Describe how in	njury occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
	ta Hospi 24 hour te Funeri letely fills	edicai (	29a. Certifier 1 Gritfying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	, death occurred at the time, date and platfor investigation, in my opinion, death o	ace, and due to the cause courred at the time, date a	e(s) and manner as s and place, and due to	stated. o the cause(s)
	To the I	Me	29b. Signature and title of certifier	Red 2	29c. License number	29d. I	Date signed (Month,	Day, Year)
7	13		30. Name and address of person who co	ampleted cause of death (Item 23a) (	Type, Print)	13   8	11/106	
	Sta	te	31. Date filed (Month, Day, Year)	32. Signature	5 Welter.	ove. Bo	alto bad	30000
	Registr		AUG 1 5 20		books			

06-05928 Please Type or Print in Black Indelible Ink John D. Callaway State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar nt's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 10, 2006 1148 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and nur Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral oreign Months Hours Director XM 2 10b. County IOc. City, Town or Location 10d Inside City Limits or items 23a or 28a-f show must be notified at once. 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? Funeral Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc Never Married Yes Yes 2 No specify Give Year Widowed 4 Divorced "natural", \$ 16b Kind of Business/Indus 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) If item 27 is marked other than " her traumatic event, the Medical Baltimore, MD 21215-0036 Be ဥ Place of Disposition (Name of cemetery crematory or other place) Removal from State Cremation 3 permit Page
Department o
Important: Other Specify of Funeral Service License Part I. Enter the disease, or complications that caused the death. Do not enter Physician failure. List only one cause on each line Between Onset and /Medical Death Methadone and fentanyl intoxication associated with pneumonia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED iten#23a,27,28a-f,perME,g858,8/31/06 T T Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown P.O. 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26 Place of Death (Check only one) examiner? Other<sub>4</sub> DOA Nursing Home 5 Residence 6 1 V Yes ۵ 28a Date of Injury (Month, Day, Year) Time of Injury 28d Describe how injury occurred 27 Manner of Death Natural 5 Pending Director: Fnd 8/10/2006 | Fnd 11:30 am unk Accident 28f Location (Street and Number or Rural Route Number, City or Town, State) 3123 Cliftmont Ave. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide 24 hours a Hamicide found at residence 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E August 11, 2006 mo 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

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State

31. Date filed (Month Oay,

Year,

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** PEGGY COLEMAN August 5:50 PM 8006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Harbor Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 25, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 217-26-9323 74 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Marylan Hygiene. Pother then 'natural', or itema 23a or 28a-f show ent, the Wadical Eastminer manter notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Packard Avenue 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny linjury or other traumatic event 9008. 17. Father's Name (First, Middle, Last) Be Joseph Salusberry Mary Buford Blanton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Sandra Munyan (Daughter) 203 Packard Avenue Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 8/15/2006 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 X. Yau 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bleeding **Physician** G.I Ascites disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hepatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death | Check only one examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 0 2 ER/Outpatient 3 DOA SIL After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending ctor: Af y the fur 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direct within 24 hours after d To the Funerei Direct completely filled in by lilled in by 4 Homicide Hospitei 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ih e M.D 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 August, 11, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 3001 S. Hanover St. Baltimore, MD Harbor ALATTAR , Hospital 32. Registrar's Signature 31. Date liled (Month, Day, Year) AUG 1 5 2006 Registrar

			1 - For State Registrar	State of M	aryland /		artment of H			Reg. No.	2000	2551	16
П	Physici	an	1. Decedent's Name (First, Middle, Last						2. Date of De Month	ath Hay	Year	3. Time of Dea	th
	/Medic		EDWARD	CLINE			# 0't T	ltio- of	12UDUA	19	County of Dea	8.2c	М
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or			46.			
_	Funeral		Northwest Hospita  5. Social Security Number 6. Se		e (In yrs. last l	birthday)	Randa.	If Under 2	4 Hrs. 8. Date of Bir	th		timore thplace (State or Fo	reign
	Director		297-20-7383	<b>M</b> 2□F	77	Yrs.	Months Days	Hours	Min. (Month, Da		Co	Ohio	
	D > 0		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wm or Lo	cation					10d. Inside City Li	mits
	Aaryla Febor	5		۸.	100. 01.7, 10			_				1 X Yes 2 □	
	28a-	rect	Maryland N/A	1			Baltimore	3		10g. Citiz	zen of What Co	puntry?	
	h with	Funeral Director	524 N. Charles St	ceet. #17	05		2:	1201			USA		
	deat me 2	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.			in? (Specify Yes or No Puerto Rican, etc.)	)-	14. Race - Ame Black, Whit		
36	or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2	No		1 ☐ Yes 2 ☑ No	Specify:				√hite	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene.  dother then "naturel", or iteme 23a or 28a-1 ehow event, the Modical Examinant he motified at	ed b	15. Decedent's Edi	Year or Dates:			dent's Usual Occupa	ation		16b. Kir	nd of Business		
215	nin 72 In na	Completed	(Specify only highest grad	le completed) College (1-4or	5+)	(Give	kind of work done of DO NOT use retired	turing most	of working			,	
21	se filed within al Hygiene. I other then vent, the Me	Com	12			Merc	hant Sear				.S. Nav	ЛУ	
Maryland	be fill d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (First, Middle				
7	should be nd Menta marked	ဥ	Edward Cline  19a. Informant's Name/Relationship (7)	ine Print)	11	9h Mailir	on Address (Street a	and Number	Helen Phi			Zin Code)	
Ma	od 2 s lth en 27 le		Walter E. Snyder/1						eet, #1700				1
re,	f Hee item othe		20a. Method of Disposition	30	20b. Place	of Dispo	sition (Name of natory or other place	e)	Date	20c. Lo	cation - City or	Town, State	
E	Page nent c int: if iry or		1 ☐ Burial 2 🏹 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,				ematory,	- 1	3/14/06	Ва	ltimore	e. MD	
Baltimore,	permit. Pages 1 and 2 should be Deperiment of Heelth end Mental Important: if item 27 le marked eny injury or other treumatic ev <u>once.</u>		21. Signatur of Tuneral Service Licens	null			2. Name and Address		OL CING CLOI	Soc	iety of	MD, Inc.	
	%			gorchik	1 th day 10				Road Balti		, MD 21	Approximate	
760,	Physician   Medical	Ical Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as Due to (or as	a consequence	e of):	STRUCTI	VE L	TING DI	5 E JA S	€ .		
.O. Box 68	death certific e attending p id for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		□Ectopic pregnancy □ Other (specify)			2	23d. Date of de Month	livery Day Year	
٥.	es that igned b be deta	by P	Part II. Other significant conditions co	ntributing to death I	out not resulting	g in the u	nderfying cause give	en in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death	
ord	w require been sig		CEREBROVASCU	LAR	HROM	B051	5		10	Yes 2	□No 3□P	robably 4 Unkr	own
Vital Records,	The la ete hes page 2	Completed	DEME	NTIA		_			24a. Was auto perfe 1 Yes	psy ormed?	24b. Were a prior to death?	utopsy findings avai completion of cause s 2 No	able of
/ita	olcian: T certificet rector, pa	Be	25. Was case referred to medical examiner?	Hospital:			10#		of Death (Check only	one)			
ō	ling Phyen.	tlon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury 288	Outpatier  Time of Injury	f 28c. Injur Wor	4 LI NU	rsing Home 5 Res 28d. Describe			ecify)	
Division	al or Attending s efter death. il Director: After id in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		jury - At home tc. (Specify)	, farm, st	reet, factory, office	10		(Street an wn, State		lural Route Number,	
	To the Hospital or within 24 hours efter To the Funeral Director Completely filled in b	edical (	29a. Certifier 175 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the besiner: On the basis and manner s	of examination	dge, deat and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and due to the th occurred at the time	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	m.11.	200 t		29c. Licens				e signed (Mon	- (	
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1	X		30. Name and address of person who o						MEHTA				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Sqis	ENTER		RANDAU	S 70	MIN MD	21	133.		
	اد Regist		31. Date filed (Month, Day, Year) 20	06	with	A	mant o						

1- State of Maryland / Department of Health and Mental Hygiene FH C858 8/15/06 Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AGNES R.CHEATHAM 2006 /Medical 4a. Facility Name (" 100 STANKI'M S 9 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore uare Hospital Kusedale tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. 8 1 931 6. Sex ge (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Days 215-28-1911 Hours 75 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2 H Raylon Drive 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo "natural", or itema r than "natural", or items the Madical Examinar in 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. heatham, Agnes altimore, Maryland 21275-0036 1 Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 Walmart College (1-4or 5+) Hygiana. Switchboard Operator as 1 and 2 should be filad w of Haaith and Mantal Hygiar fitem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Ruley Sentina Lombardi 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43440 Wild Dunes Square-Leesburg, Virginia 20176 Sentina A. Jaecklein-daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State it. Pagas 1 intmant of F cemetery, crematory or other place) parmit. Pagas Dapartment of Important: If it any injury or o 8-12-06 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road-Parkville, Maryland 21234 Inda 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition respirator **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attanding physician and for usa as tha burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown thyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No this cartificata 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 70 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Aftar thi 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending daath. investigation 1 ☐ Yes 2 ☐ No 2 Accident tha Director: 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of to the Funaral Direct complately filled in by 4 T Homicide the Hospital VC Certifying Physicien: To the best of my knowledge death, count at the lime, date and place and due to the cause(s) and manner at stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of death (ttem 23a) (Type, Print) 9000 Franklin Square 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 15 Registrar

			For State of Ma	ıryland		artment of	f Health and of Death	Mental Hy	/giene200	6 25548
			Decedent's Name (First, Middle, Last)					2. Date of D	eath	3. Time of Death
	Physicia		Robert Russell Crampton,	Sr.				Month	Day Yea	1 117-11 11
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		1	4b. City, Town	n, or Location of Deat		4c. County of De	
			Franklin Square Hospit	al C	enter	R	osedale	>	Boilt	imore
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. la	ast birthday	Months Da		8. Date of B	irth 9. B	irthplace (State or Foreign Country)
	Director		2.0 20 0070	75	Yrs.		<b>'</b>		12, 1931 M	
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
	Maryland f ehow	ក	Maryland Baltimore	Esse						1 ☐ Yes 2ÃÃNo
	28e-1	ect	10e. Street and Number	поос		10f. Zip Cod	Α		10g. Citizen of What	Country?
	with a or	Funeral Director	2220 Monocacy Road				1221		U.S.A.	,
	ne 23	era	11. Marital Status 12. Was Decedent E	Ever in U.S	S. 13.		of Hispanic Origin? (S Juban, Mexican, Puer	specify Yes or N		nerican Indian,
+ 10	riter	ᆵ	Amed Forces?  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes, Give	lo				to Rican, etc.)	Bfack, Wi	nite, etc.
036	el', o	ρ	3 ☐ Widowed 4 ☒ Divorced   If Yes, Give Year or Dates:	unk.		1 ☐ Yes XX	No Specify:		Specify: V	Vhite
Robert 21215-0036	72 ho	Be Completed by	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	edent's Usuaf Oc	cupation	rkina	16b. Kind of Busines	s/Industry
27.0	ithin	nple	Elementary/Secondary (0-12) Colfege (1-4or 5	+)			ne during most of wo tired)	9		
21	ygier ygier her th	ပ္ပ	10		Driv	er	1.0 1.1 1.1	· · · · · · · · · · · · · · · · · · ·	Steel Comp	pany
Pu	be fill	Be	17. Father's Name (First, Middle, Last) William Crampton						e, Maiden Sumame)	
\( \frac{2}{8} \)	d Mer narke	10			40h M-11	in . A d d /Can	Ruth Ni		ber, City or Town, State	7:- Co-tol
rampton jaltimore, Maryland	12 st h and 7 io r traur		19a. Informant's Name/Relationship (Type, Print)  Robert Crampton, Jr. (Son)		1	100				
G - G	1 and Healt em 2		20a. Method of Disposition	20b. PI	lace of Disp	osition (Name of		Date Date	re, Marylar	
ام ح	ages nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	- 1		matory or other		15 2006	D=1+4	N
Fam Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "neturel; or Iteme 23a or 28e-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Secrets Licensee	210	ni Cilu	2. Name and Ad	dress of Facility	15,2006	Baltimore	Maryland
Ba	Dep Find		133			1407 Old	Bruzdzińsk J. Fastorn	i Funer	al Home, P. Essex, Mar	A.
			23a. Part1. Enter the disease, or complications that caused	the death						Approximate
	Physician		shock or heart failure. List only one cause on each lin	ie.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a condition of the condition of	a consequ	uence of):					
	Examiner		Pneu	me	mia					
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consecu	ianea of):					
$\vee$	outed nd transi	Examiner	The state of the s							
,00	be executed sician and burial-transit	I Ex	Due to (or as a	a consequ	uence of):					
68760,	cate be executed physician and the burial-transit	dicai	d.							
		Me	IF FEMALE:	of ======		-				
Во	eath certift attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	2 Fetaf	death 3	Ectopic pregna			23d. Date of o	lelivery Day Year
o.	that the death cer ed by the attendir detached for use	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of de	eath 5	Other (specify	y			
o.	that the ed by detac	by Physician/Me	Part II. Other significant conditions contributing to death but	ut not resu	ulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Sp	w requires that been signed should be det		Esophageal Cance	5				15	Yes 2 No 3	Probably 4 Unknown
S	w requ	lete	Atrial of ballation	^	_			24a. Wa	s an 24b. Were	autopsy findings available
Re	he la e has	Completed	THE TIBILIANO		7.1			auto	opsy prior t formed? death	o completion of cause of ?
<u>a</u>	ifficate or. pa	ပိ	25. Was case referred to medical		olit	15	26 Place of De	1 ☐ Yes ath (Check only		es 2 No
<u> </u>	ysician: The lar is certificate has director, paga 2	To Be	examiner? 1 Yes 2 No Hospital: 1 Impatie		ER/Outpatie	ent 3 DOA	Othor		sidence 6 Other (Si	paciful
ō	ding Phys h. After this funeral di	n: T	27. Manger of Death 28a. Date of Injur		28b. Time of		njury at Work?	T	how infury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division of Vital Records, P.O. Box	or Attending Physician: The law requires that the death certift death. Director: Atler, this certificate has been signed by the attending in by the funeral director, paga 2 should be detached for use as	Certification:	2 Accident investigation	, oar,	mjury		1 Yes 2 No			
ivis	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnju building, etc	ury - At ho	me, farm, s	treet, factory, off	ice		(Street and Number or own, State)	Rural Route Number,
	ital o	Cer								
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	examinat	wledge, dea tion and/or i	th occurred at th nvestigation, in r	e time, date and plac ny opinion, death occ	e, and due to the urred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
	To the withing To the comp	Me	29b. Signature and title of certifier				ense number		29d. Date signed (Mo	nth, Day, Year)
			1 12 ~~			DØ	8Ø63 Ø54		Progret 12,	2006
	341	Į.	30. Name and address of person who completed cause of de					,		
	,					Ellicott (	ity, mo 2	1043		
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registra	ar's Signat	ture	heel )				

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of He rtificate of D		-	giene 2001	5 25549
	Physicia	an	1. Decedent's Name (First, Middle, La	st)		061660	70	2. Date of De Month	Day Yea	
ų.	/Medic	al	GEOLGE			CEASER,		AUGUS	4c. County of De	
1	Examin	er	4a. Facility Name (If not institution, giv	PKINS H	relisal	4b. City, Town, or L	isation of Deali		4c. County of De	N/A
	Funeral Director		5. Social Security Number 6. S 187-32-9509		(In yrs. last birthday) 66 Yrs.	The state of the s	If Under 24 Hrs. Hours Min.	(Month, Da	th 9. E ay, Year) 8, 1939	irthplace (State or Foreign Country) Virginia
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	eation				10d. fnside City Limits
	Aaryla Febor	ō	Maryland	N/A	,,		altimore			1 Yes 2 No
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	h with	al D	2605 East Chase Stre	et			21213		L	J.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hylury or other treumatic event, Ite Medical Examinar must be notified at ance.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☐ <b>Xi</b> o	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. Black
Š	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usuaf Occupat kind of work done du	tion	dena	16b. Kind of Busines	ss/industry
21215-0036	thin 7	Completed	(Specify only highest grant Elementary/Secondary (0-12)	Coflege (1-4or 5-	life.	DO NOT use retired)	ction Worke		Private C	onstruction Co.
7	led will her the		12. Father's Name (First, Middle, Last	3					, Maiden Sumame)	
and	d be fi	) Be		T. Ceaser Sr			15. 111511151 5 1141		ucille Whack	
Maryland	should nd Me mark mati	은	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street ar	nd Number or Ru	ural Route Numb	er, City or Town, State	, Zip Code)
Ĭ	and 2 alth a 127 is		Tyrone Ceaser Son		2	2605 East Cha	se Street B	altimore, Ma		
Baltimore,	Pages 1 and part of He and the featury or other		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Speci	or Town, State Vne, Maryland						
Balt	permit. Depertr Importa any Inju		21. Signatur of Funeral Service titoe	2. Nals	Ser Je 2	2. Name and Address Estep B 1300 Et	rothers Fur	neral Service Baltimore, M	e, P. A. Md 21217	
,	Physician	4	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	the death. So not enter	AND VOL				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in accumy		consequence of): AGE REN	A DISEA	CE ON	HEMOD	IAWSIS	1 MONTH
		e	Sequentially list conditions, if any, leading to immediate		consequence of):	in C Proper	30	1,000	17-12-1	
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		TE CANCE	er .				3 YEARS
,0928	cate be executed physicien and the burial-transit	EX	resulting in death) Last	•	consequence of):	GEICIENC	N MPAS	ς		9 YEARS
387		dicai		d. Durvis			7 (1,000)			1 10.17
.O. Box (	that the death certified by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of o Month	delivery Day Year
Vital Records, P.	se us	ρ	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	inderlying cause give	n in Part I.	1		to the cause of death?  Probably 4 □Unknown
cor	w requir s been si should	Completed						24a. Was	s an 24b. Were	autopsy findings available o completion of cause of
Re	The lay	omi						auto perf 1 ☐ Yes	ormed? prior death	? _
ital		Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only	one)	
of V	S 5	၉	1 ☐ Yes 2 ☑ No	Hospital:			4   Nursing r		idence 6 Other (S	pecify)
n C	ding Ph h. After thi funeral	lon;	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time o Year) Injury	Work	at ? ′es 2 ∐No	28d. Describe	how injury occurred	
Division	or Attended of the death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	De Dingo of Init	iry - At home, farm, st . (Specify)		-		(Street and Number or wn, State)	Rural Route Number,
_	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: Atter completely filled in by the funer	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	th occurred at the time expecting tion, in my op	e, date and place inion, death occ	e, and due to the urred at the time	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (Mo	
	1		/ Ceni & Wood	TMEDICAL 1	DUGTOK	RES-	U00		August 13,	WUB
0	2		30. Name and address of person who KEVIN WOODS, THE JOH	o completed cause of de	seath (ftem 23a) (Type SPITAL, 600	NOWH WOLF	ie smea	, BAUTIM	ORE, MANYU	SND: 21287
1	Sta Regist	ate	31. Date fifed (Month, Day, Year)		ar's Signature	·		•		

		•		aryland / Depa	artment of Health and Nartificate of Death	Mental Hygie	_	25550
ŀ	Physici: /Medic		Decedent's Name (First, Middle, Last)     THOMAS M. CONNELLY	JR.		2. Date of Death Month AUGUST	Day 2 Year 2 0 0	3. Time of Death 4:00p M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of De	
			ST. MARY'S HOSPITAL		LEONARDTOWN If Under 1 Year   If Under 24 Hrs.	O Data of Birth		ARY'S
	Funeral Director		5. Social Security Number  216 14 7386  Usual Residence of Decedent	83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y JUNE 30	1923 MA	inthplace (State or Foreign Country) RYLAND
	Maryland 8-f show	ctor	10a. State         10b. County           MD         BALTIMORE	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What C	Country?
	e 23a		8411 AVERY ROAD	Fire in ILS 42	21237	acety Vas or No	14. Race - Am	JSA
920	urs after de al', or Item Examinar	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 ☑ Yes 2 □ If Yes, Give Year or Dates!	NO TOTAL	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 為最No Specify:	Rican, etc.)	Black, Wh	to a
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28a-f show other traumatic event, II a Madical Examinating the inciliant at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or to the control of	5+)	dent's Usual Occupation kind of work done during most of work DO NOT use retired) SPATCHER	sing 16	TRUCKIN	•
Maryland 2	should be filed withir ind Mental Hygiene. s marked other then umatic event, Ite M	To Be Co	17. Father's Name (First, Middle, Last)	SR.	18. Mother's Nam	ue (First, Middle, Ma	uiden Sumame)	
lary	and N ls ma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rui			
	and lealth m 27		ED WELSH / PERSONAL RE	P. 1108 20b. Place of Dispo	CEDAR CREEK RO		TIMORE,	MD 21221
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	HoLY RE	DEEMER 8/1	7/06 E	BALTIMOR	RE, MD
Balt	permit, Departr Importe any inje		21. Signature of Europea Service Lightnesse	1	2. Name and Address of Facility CV 211 CHESACO AV	ENUE BAI	TIMORE,	
	Physician /Medical		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition resulting in death)	IF.	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Examiner	<u>.</u>	Due to (or as	s a consequence of):	fæilme Pneymor			> week
2	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Pination a consequence of):	- Pneymor	1) 9		> week
68760,	cate be executed physician and the burial-transit	cal		sphaji	4			> 2 mont
P.O. Box 6	The law requires that the death certificate attending phy ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of d Month	elivery Day Year
	juires that n signed t uld be det	d by P	Part II. Other significant conditions contributing to death t	out not resulting in the u		23e. Did toba		to the cause of death?  Probably 4 Dunknown
Records,	hysicien: The law requir his certificate has been si I director, page 2 should	Completed by	C. J. H colitis,	•		24a. Was an autopsy performe	prior to	
/ita	sien: artifica ctor, I	Be C	25. Was case referred to medical examiner?			th (Check only one)		
of V	Physicien: or this certific eral director,	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati 27. Manner of Death 28a. Date of Inju	ury 28b. Time o	of 28c. Injury at	ome 5 Residen 28d. Describe how		pecify)
Division of Vital	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined 28e. Place of In building, e	jury - At home, farm, stite. (Specify)	Work? M 1 □ Yes 2 □ No reet, factory, office	28f. Location (Stre City or Town,		Rural Route Number,
ā	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	cal Cer	29a. Certifier  (Check only 2 Medical Examiner: On the basis of	of my knowledge, deat	th occurred at the time, date and place	, and due to the cau	ise(s) and manner a	as stated.
	the H hin 24 the Fi	Medical	one) and manner si		29c. License number		d. Date signed [Mor	
)	with To con	4	29b. Signature and title of certifier , 6	no	700622\		8 11 0	/
	4		30. Name and address of person who completed cause of DR. SURESH PATEL 255			EONARDTO	OWN, MD	20650
	∍ Sta			rar's Signatur				-

Thomas Connelly

			For State Registrar	State of	Marylar		artment of rtificate of				iene	16	255	51
	<b>D</b> I		1. Decedent's Name (First, Middle, L	ast)					2	2. Date of Deat Month	Day	Year	3. Time of	Death
	Physici /Medic			BETT	LEE	COREY				ugust	8, 20	0°6°	8:37	Рм
	Examin	er	4a. Facility Name (If not institution, g.		nber)		4b. City, Town,		of Death		4c. County			
			7955 Holly Ro 5. Social Security Number 6.		7. Age (In yrs.	last birthday)	Pasa If Under 1 Yea		24 Hrs.   8	R Date of Birth	Anne			r Foreian
ı	Funeral Director			1 □ M 2 🗷 F	75		Months Day	s Hours	Min.	3. Date of Birth (Month, Day, 09/07/	1930		olace (State or otry) vland	
			Usual Residence of Decedent			ty, Town or Lo								
	shov	<u>_</u>	10a. State 10b. County	1			cation						0d. Inside Cit 1 ☐ Yes	
	28e-f	rect	MD Anne A	runde1	Pas	adena	10f. Zip Code			1	Og. Citizen of V	Vhat Cour	ntry?	
	after death with the Marylan or Itams 23a or 28e-f show	Funeral Director	7955 Holly Ro	aď				211	22		U.S.	. A .	,	
	death	nera	11. Marital Status		dent Ever in U	I.S. 13.	Was Decedent of f Yes, specify Cu			ity Yes or No-	14. Race		can Indian,	
36	72 hours after death with the Maryland natural', or Itams 23a or 28e-f show Jisal Eva' I writment be incilled at		1 ☐ Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 <b>⊠</b> No e		1 ☐ Yes 2 <b>⊠</b> N			,,	Specify			
Ö	hours tural'	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Da	ites:	16a Decer	dent's Usual Occ	unation			16b. Kind of Bu		ite	
15	n "na	plet	(Specify only highest g		Acr E ()	(Give	kind of work don DO NOT use reti	e during mos	st of working	7	TOD. KING OF DO	101110004111	austry	
212	od within giene. er than "	Completed	12	Conage (1	-401 547		Homema	cer			Own Ho	ome		
pu	be filed within 72 hours a ntal Hygiene. Ind other than "natural", o evant, The Medical Evar	Be	17. Father's Name (First, Middle, Las								Maiden Sumam			
₹	2 should be and Mental Is marked (	<sup>2</sup>	40 Information Name (Deletionship	Earl V	Vessel	-		· · · · · · · · · · · · · · · · · · ·			Bock		Codel	
Maryland 21215-0036	s 1 and 2 should f Health and Mer itam 27 Is marke other traumatic		19a. Informant's Name/Relationship Daniel Corey,		shand		ng Address <i>(Stre</i> 5 Holl:				-	31a16, 211 2112	_	
ē,	ss 1 and 3 of Health itam 27		20a. Method of Disposition		20b. l		sition (Name of natory or other p		Da	<del>_</del>	20c. Location -			
E O	Pages nent of int: If it iry or o		1 ☐ Burial 2 【Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		State				08/11	/06 H	Baltim	ore	MD	
Baltimore,	permit. Pages Department of I Important: If its any injury or o	A Donation 5 Other (Specify)  Bayview Crematory 08/11/06 Baltimore, MD  21. Signature of Fineral Secreta Licensee  22. Name and Address of Facility G. J. Gonce Funeral Home, 169 Riviera Dr. Pasadena, MD 21122												PA
	. *		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that c	aused the deat	th. Do not ent	er the mode of d	ying, such as	cardiac or	respiratory arre	est,		Approximate Interval Bety	veen
	Priysician	( I)	Immediate Cause (Final disease or condition	_ a.	S	mall	Cell L	ing C	ancei	r			Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (	or as a consec	quence of):								
		-e	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a consec	quence of):	-					-		
B	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause spinsage or impary that initiated events	C.										
0,	sician and burial-transit		resulting in death) Last		or as a consec	quence of):								
8760,	ate hy:	edlcal		d					_			-		
9 xo	eath certific attending p for use as (	/Me	IF FEMALE:	23c. If yes, out	come of prean	ancv					23d Dat	e of delive	an.	
Bo	leath atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No	1 🗆 Live b	irth 2 ☐ Feta ant at time of c	al death 3□	Ectopic pregnar Other (specify)	icy			Mor		-	'ear
0	the y th iche	hysl	9 Unknown	9□ Unkno	wn									
Vital Records, P	es thi	by	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the u	nderlying cause (	given in Part I	l. 		oacco use contr es 2□No		ne cause of de pably 4 □U	
900	e taw requir has been si je 2 should	pleted								24a. Was a	n 24b. V	Vere auto	psy findings a mpletion of ca	ivailable
H.	Th ate pag	Compl								perforn	ned? [ d	leath?		400 01
/ita	Physician: this certifica ral director, p	Be (	25. Was case referred to medical examiner?	Hospital:						Check only on				
of	Physic this cral dir	To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of	28c in	urv at			ence 6 Othe		y)	_
	Attanding r death. actor: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Mon	h, Day Year)	Injury	W	ork? □Yes 2□			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Division	Diriginal Control	ertification;	3 Suicide 6 Could not 4 Homicide determine	288. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, offic	е	28	8f. Location (St. City or Town	reet and Numbe n, State)	er or Rura	l Route Numb	er,
	Hos Hos Fun Tely	edical C		Physician: To the aminer: On the ba and man										
	To the within 2 To the comple	Me	29b. Signature and Atle of certifier	1			29c. Lice	nse number		25	9d. Date signed	(Month,	Day, Year)	
)	¢		· men		MD		D 00	58779	9	A	ugust	10,	2006	
	4		30. Name and address of person who Karl Kasamon,	MD 30	e of death (Ite	pital	Dr. G	len E	Burni	e, MD	2106	1		
	Sta		31. Date filed (Month, Day, Year)	006 328	egistrar's Sign	ature An	reles							
	Registr	ar	AUG 1 5 2	UUD III	Julius A	s. Jajo	7-9-0-							

		•	For State Registrar	State of Marylar	•	artment <i>rtificate</i>			Mental i	Hygier Reg. I	- /	0.5	255	552
102	100		Decedent's Name (First, Middle, Last)						2. Date o	f Death			3. Time of	Death
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	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, T	Town, or L	ocation of De			4c. County		x x	
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)# #	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under	1 Year	If Under 24 H	rs. 8. Date o	f Birth		9. Birthol	ace (State or	Foreign
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	D .		Usual Residence of Decedent											
	rylar		10a. State 10b. County		ty, Town or Lo							10	0d. Inside Cit	
	e Ma	cto	Maryland Anne Arı	indel An	napo1	1S							1 TYes	2   NO
	or 26	Directo	10e. Street and Number			10f. Zip	Code			10g.	Citizen of V	What Coun	try?	
	23a	rall	7 College Creek	Terrace			1401				JSA			
	ema er e	Funeral		<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	.S. 13.	Was Decede If Yes, speci	ent of Hisp rfy Cuban,	anic Origin? Mexican, Pu	(Specify Yes o erto Rican, etc.	r No- )		e - America k, White, e		
36	s afte	by Fi	1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give		1 ☐ Yes 2	. □ <b>X</b> No	Specify:			Specify	. Bla	ck	
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21215-0036	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual kind of worl DO NOT use	k done dui e retired)	ring most of w	vorking		. Kind of Bu		•	
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Maryland	od be	To Be	John H. Collins					Tanice	e Bati	ste				
2	should nd Mer marke imatic	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address			Rural Route No		y or Town,	State, Zip	Code) 21	061
Ξ	ith al 27 is		Cheryl Smith(Sis	ster)	308	High1	Land	Dr. A	Apt T3	G1e	n Bu	rnie	, Md.	
ē,	ss 1 and 2 should of Health and Me item 27 is mark cother traumation		20a. Method of Disposition	20b. I	Place of Dispo	sition (Nam	e of		Date	-	Location -			
9	Pages nent of int: If it		1 ☐ Burial 2 MCremation 3 ☐ Re  3 ☐ Other (Specify)		tro C				15-06	Ba	ltim	ore.	Ма	
Baltimore,	C 40 -3		21. Signature of Funeral Service License							1			110.	
ñ	permit. Departimport Import any inj		Janu H Ro	ese MOO48	3 8	m. Re 21 We	ese	& Sor	ns Mor nnapol	tuar	y, P	A.	1	
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	Dhysisian		shock, or heart failure. List only one Immediate Cause (Final		monia								Onset and D	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consec									days	
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Ó	tifica ng ph as th	led												
ROX	eath certific attending p	N/UE	23b. was decedent pregnant	lc. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta		Ectopic pre	anancy					e of delive		
	deat	SICIS	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 Pregnant at time of c		Other (spe				_	Moi	nth	Day Y	ear
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0	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	Bc. Injury a Work?	t	28d. Descr	ibe how in	ijury occurr	ed		
0	Attendii death. ctor: A y the fu	atle	2 Accident investigation			М	1 🗌 Ye	s 2 No						
Division of	r Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory,	office		28f. Location City or	on (Street Town, St	and Numbi ate)	er or Rural	Route Numb	ιer,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		<b>.</b>	Į.										
	Hosp 4 hot Fune ely fil	edical	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina	owledge, death ation and/or in	n occurred a vestigation,	at the time, in my opin	date and pla	ce, and due to curred at the ti	the cause	(s) and ma and place, a	nner as sta and due to	ited. the cause(s)	
	the hin 2 the l	Med	опе)	and manner stated.			License n							
	5 1 3 S	-	29b. Signature and title of certifier	(Bech, MD		290.	D	16052		230.1	Date signed	I INIONIN, L	ray, rear)	
•	0			(17004)			-11			(	1/9	06		
0	2		30. Name and address of person who con	npleted cause of death (Iter	п 23а) (Туре.	Cicel	Park	way	annal	olis.	Mo			
	Sta	10	31. Date filed (Month, Day, Year)	32. Restrar's Signa		7				/				
	Sta Registr		AUG 1 5 20	497	K A	parke	,							

State of Maryland / Department of Health and Mental Hygiene.

Amend #20a\_c &22 PER FH G858 8/21/06 Certificate of Death

Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Auguss Year M9 015 **Physician** 2006 James Dallam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Annapolis Nursing & Rehab Annapolis Anne Arundel If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 157 M 2□ F 59 Dec 21, 1946 217-50-4045 Maryland Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Heatth and Mental Hygiene. int: If item 27 Is markad other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location items 23a or 28a-f shor 1 ☐ Yes 2√ No MD Anne Arundel Annapolis Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 900 Van Buren Drive 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0020 Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 musician entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Harry Preston Dallam Kathryn Coad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Catherine Dinges/sister 20a. Method of Disposition
1 □ Burial 2 □ Acremation 3 □ Removal from State Department of important: If it any Injury or concept of the process. 8/08/2006 Beltsville,MD. 4 □ Donation 5 ₩Other (Specify) in state Chesapeake Crematory 22. Name and Address of Facility Cremation & Funeral Alternatives State Anatomy Board 655 W. Baltimore Street Baltimore, MD Pastures Drive Balto.Md. 21286 21. Signature of Funeral Service Licensee Ronald 3. Wade 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** a Antenios chenotic Candiovasculan Disease Immediate Cause (Final disease or condition resulting in death) cars /Medical Examiner Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☑ No 3 Probably 4 Unknown Granic Obstructive lung Disease by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No TE Yes 2 Line To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P01852 Name and address of person wholecompleted cause of death (Item 23a) (Type, Print) 4203 Queensburg Rd Hyatts: 112 MD 20781 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Marylar		artment of H		Mental Hy		25554
	-		negistrar     Decedent's Name (First, Middle, Last			timodic of i	Douth	2. Date of D	Reg. No.	3. Time of Death
	Physici		JERRY Le	ster Do	ffm	eyer		Augu.	St 11 2006	3120P M
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat		4c. County of Dea	
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	Funeral Director		1 10 // - 1	7. Age ( <i>lin yr</i> s	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D	9. Bir 29, Year) Co 3, 1946	tholace (State or Foreign buntry) MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Aaryik Feho	5	MD Carrol			neytown				1 ☐ Yes 2√ No
	the /	ect	10e. Street and Number	_	101	10f. Zip Code			10g. Citizen of What Co	21.
	3a or	Funeral Director	4620 Sundown Dri	ve			21787		USA	,,
	death	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Was Decedent of H	ispanic Origin? (S	pecify Yes or N	0- 14. Race - Ame	
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21	THE R. L. LEWIS CO., LANSING, MICH.		12		Tri	ıck Drive			Construct	ion
Maryland	B la b	Be	17. Father's Name (First, Middle, Last)	fmarrar					e, Maiden Surname)	
3	d Mental marked c	ဥ	Joseph E. Dof		401 14 11		Pauli			
Ma	d 2 should th and Mer ?7 is marke treumatic		Mrs. Georgeanna L.	(Wife)					ber, City or Town, State,	ZIP Code)
	1 an Heal em 2		20a. Method of Disposition	20b.	Place of Dispo-	sition (Name of		neytown Date	MD 21787	Town, State
no	100		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cren	natory or other plac	' 8/1	7/2006		
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licens	, ou	rrison	Forest V	et tem.		Owings Mil	IS, MD
Ba	Departr Imports eny inju		> Blian L H	aut Moore		JAKEZATTT	e. Pu Zi	104 141	PEL, PA (Bo: 0)-795-1400	( 195)
П			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the dea ne cause on each line.	٨			or respiratory a	arrest,	Approximate Interval Between Onset and Death
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Δ.	requires that the leen signed by th hould be detache		Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use contribute to	the cause of death?
rds,	puires n signe	d by						10	Yes 2□No 3□Pr	obably 4 Unknown
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Division of Vital	al or Att	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre fy)	eet, factory, office			(Street and Number or Ruwn, State)	iral Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of my knowner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the cred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	ro the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Monti	h, Day, Year)
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	7		Penali Noticewa			Leene.	Street	+ Balt	imore ms	21201
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E	Physici		Decedent's Name (First, Middle, La:     Carmella	L.	Dic+	efano				2. Date of Deat Month August	Day 13, 20	Year 106	3. Time of De 4:45 a	
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			Futurecare Cher	rywood				Rei	sterstow	n	Bal	Ltimo	ore	
1	Funeral Director		5. Social Security Number 6. S 217-05-6018	ex □M 2\$€F	7. Age (In yrs. 86	. last birthday) Yrs.	If Unde Months	r 1 Year_	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) , 1919	Cour	lace (State or Fo stry) aware	oreign
	p.		Usual Residence of Decedent		10.0					1 - 1 - 1	,			
	show	_	10a. State 10b. County		10c. C	ity, Town or Lo						1	0d. Inside City L 1 ☐ Yes 2	
	he M	Director	MD Balt  10e. Street and Number	imore		Owi		Mills	<u> </u>		0- 00-			
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320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or itams 23a or 28a-f show say injury or other treumatic event, Ite M. drall Extruibat rotal be notified at ODGE.	by Fun	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed For 1 Yes If Yes, Gir Year or D	orces? 2⊠No ve		f Yes, spe I□Yes	cify Cuba	n, Mexican, Puerti Specify:	o Rican, etc.)		, White,		
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Rox	The law requires thet the death certif tie has been signed by the ettending page 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn		Estania r	regnancy			23d. Date	of delive	iry	
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a	ilcian: Th certificate rector, pag									1 Yes 2	<u>P</u> N₀ 1	Yes	2□ No	
5	sicia certi irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Innation OF	758/0		Othe	\r_	th (Check only on				
ō	y Phys er this eral di	7: To	27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of		28c. Injury Work		ome 5 Reside			′)	
<u> </u>	nding ath. r: Afte	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation		th, Day Year)	Injury	м		c? Yes 2 □ No					
Division of Vital	Hospital or Attending I 4 hours efter death. Funerel Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	286. Place	of Injury - At I ing, etc. (Spec	nome, farm, str	eet, facto	ry, office		28f. Location (St. City or Town	reet and Numbe , State)	r or Rura	l Route Number	۲,
	To the Hospital or Attending Physician: The within 24 hours either dauh.  To the Funerel Director: After this certificate ha Completely filled in by the funeral director, page	edicai C	29a. Certifier 1 Certifying Ph (Check only one)	niner: On the b	best of my kn asis of examin ner stated.	owledge, death ation and/or in	occurred vestigation	d at the tim	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	tuse(s) and mar ate and place, a	iner as si nd due to	ated. the cause(s)	
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			,	29	c. License	number	2	d. Date signed	(Month,	Day, Year)	
	7		Stor	Sa	in-1	mn		n2	8704		8/14	10	6	
7	6		30. Name and address of person who	completed caus	se of death (Ite	m 23a) (Type,	Print)	42	0307	D	-/1/		+ outn	
	2		Stephen 9	i'eg.	elmo		75	op	nain S	t, R	mib	21	136	,
8	Sta Regist	5	31. Date filed (Month, Day, Year)	-32.5	gistrar's Sign	ature	and.	2						

			1 - For State Registrar	State of M	aryland		artment tificate			ind M	ental Hy	gien Reg. N	201	36	25	556
П	Physici	an	1. Decedent's Name (First, Middle, Last)	OBISI	115						2. Date of De	eath Da		Year	3. Time of	Death A M
	/Medio		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	f Death	NUG	4	. County o	Death	10.	
	Exami		MERLY H	OSPIT	AL		B	ACT	7070	NE			1	N/A		
	Funeral Director		214-52-8545	7. Ag	ре (In yrs. la 58	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Di Apr. 1	rth ay Year 5,	1948	9. Birthp Coun Ma	lace (State or try) ryland	Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Cit	y Limits
	a-f eh	ctor	MD Queen	Anne's		S	udler	svi1	.1e						1	2 📉 No
	with th	Director	10e. Street and Number				10f. Zip		. 0			_	itizen of Wi		*	
	eath v	Funeral	129 West Main Stre	12 Was Decedent	Ever in U.S	3 13 1		2166		nin? (Sna	ofy Yes or No		ted S			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or items 23a or 28a-f ehow spir injury or other traumatic event, the Medical Examinar must be notified at once.	þ	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1  Yes 2 2 If Yes, Give Year or Dates:	•	1	Yes, spec			, Puerto I	cify Yes or No Rican, etc.)			White,		
15-0	"natu	Completed	15. Decedent's Edu (Specify only highest grade			16a. Deced	lent's Usua kind of wor OO NOT us	l Occupa k done d	ition u <i>ring</i> most	of workii	ng	16b. h	Kind of Bus	iness/ind	lustry	
212	d within	ошо	Elementary/Secondary (0-12)	College (1-4or	5+)		lomema						Own	Home		
ng	al Hyg	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maidei				
yla	ould I	ပ	James V. Harrison	0.10							rno1d					
Ma	of 2 sl		19a. Informant's Name/Relationship (Ty William E. Dobbins	,	nd						I Route Numb Sudlers				•	
Baltimore,	es 1 ar of Hee fitem rothe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R		20b. Pla	ace of Dispo	sition (Nam	e of			ate		ocation - C			
ij	Pag tment tent: I	1	4 Donation 5 ☐ Other (Specify)	emoval from state		rownsv	ille		1 8		-2006		ownsv			
Bal	Depar Depar Impor eny in	(	ST STORY OF THE STREET	THOUT	TM						rose Fu					
			23a. Part1. Enter the disease, or compli	cations that cause	the death.	. Do not ent	328 S or the mode	ultp!	nur Sj J, such as (	pring cardiac o	g Rd., r respiratory a	Arbi	utus,	MD	Approximate	)
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	le cause on each i	6	mic	TS	06	EL						Interval Betwood	eath
	/Medical Examiner		resulting in death)	Due to (or as							·				V	
		er	Sequentially list conditions, if any, leading to immediate	Dua to (or as	a curisequ	arica of):										
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8760,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):										
687	ficate physi s the t	edica													·	
Вох	death certificate be executed e attending physicien and id for use as the burial-transit	an/Me	230. Was decedent pregnant	3c. If yes, outcome			Ectopic pre	ana nov					23d. Date	of delive	гу	
o.	the che	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown			Other (spe						Mont	h	Day Y	ear
Δ.	The law requires thet ate hes been signed boage 2 should be deta	by Pi	Part II. Other significant conditions cor	tributing to death b	ut not resul	lting in the un	iderlying ca	iuse give	n in Part I.		23e. Did t	tobacco	use contrib	ute to th	e cause of de	ath?
ord	w requir been si should I	eted									10	Yes 2	□No 3	☐ Proba	ably 4 📶	nknown
Division of Vital Records,	he law shest ge 2 s	Completed									24a. Was auto		DU	ere autop or to con ath?	sy findings a opletion of ca	vailable use of
ta	an: Ti tificate tor. pa	0	25. Was case referred to medical	- 44	J-22 77				26 Place	of Death	1 ☐ Yes	2 N	1	Yes	2□ No	
<u> </u>	Physician: r this certific ral director,	To B	examiner?	ospital:	ent 2 🗆 E	R/Outpatien	3 DO	A Othe	-		ne 5 Resi		6 □Other	(Specify	)	
0	Ing Pt		27. Manner of Death  S☐ Natural 5☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	2	8d. Describe	how inju	ry occurred	1		
isio	Attending r death. •ctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 □ Could not be	28e. Place of Inj	un. At hos	mo form star	M		'es 2□N		8f. Location (	Straat	ad Numbar	or Dura	Paula Munh	
<u>S</u>	tal or A	Certification:	4 Homicide determined	building, et	c. (Specify)	)	er, raciory,	OIIIC		-	City or To	wn, Stati	a)	or Aurai	House Numb	θ1,
	To the Hospital or Attending Physician: The within 24 hours alide death.  To the Euhoreal Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier Certifying Physical Check only one)	ician: To the best ter: On the basis o and manner st	f examination	vledge, death on and/or inv	occurred a estigation,	t the tim	e, date and inion, deatl	d place, a h occurre	nd due to the	cause(s date an	) and manr d place, an	er as sta d due to	ited. the cause(s)	
	To the within 2	Med	29b. Signature and title of certifier	and mellior St	00.			License					ite signed (			
	. , , , ,		) Josh C	esta.	25	>	1	5-1	26	34	_	A	1G	0,	2000	0
	1		30. Name and address person who co			23a) (Type, i	Print)	N/	<b>\</b>		BAT			<i>(</i> )		
	Sta	te.	31. Date filed (Month, Day, Year) 200	32 Registr	SO   ar's Signaf		100	<u></u>	1-64	U	1547	CTIV	TORE	VIC	) (12	,02
3	Registr		AUG 1 5 200	O ALBERTA	الناكر م	158	N. C. C.									

		Registrar     Decedent's Name (First, Middle, La				ate of Death		2. Date of Deat	Day	Year	3. Time of Death
ysici Nedio			Mildred N	4. Dile				August	13,		3:45 P
amin	er	4a. Facility Name (If not institution, gr	e street and number)			ty, Town, or Location	of Death			ounty of Death	
eral		Holly Hill Manor  5. Social Security Number 6.5	Sex 7. Age	(In yrs. last birti	nday) If Und	OWSON der 1 Year   If Under	r 24 Hrs.	8. Date of Birth (Month, Day)			e County place (State or Foreigntry)
ctor		220-14-3705 Usual Residence of Decedent	1□M 2⊠F	94	rs. Month	S Days Hours	Min.	Jan. 24	, 19	12 Mar	yland
led at	tor	10a. State 10b. County  Maryland Baltim	ore Co.	10c. City, Town	or Location						10d. Inside City Limit 1 ☐ Yes 2XX
The not	Funeral Director	10e. Street and Number 531 Stevenson Lan			10f.	Zip Code 212	86	1	0g. Citize	en of What Cou USA	intry?
E I	Jera	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was De	cedent of Hispanic Or pecify Cuban, Mexica	rigin? (Spec	ify Yes or No-	14	1. Race - Amer	
event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3XXXVidowed 4 Divorced	Armed Forces?  1 Yes 2244  If Yes, Give Year or Dates:	0		pecny Cuban, Mexica		iicari, etc.;	S	Black, White Specify:	white
Scal	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's U (Give kind of	sual Occupation work done during mo use retired)	st of workin	g	16b. Kind	d of Business/li	ndustry
e Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	Homen					In own	home
m, m		7th 17. Father's Name (First, Middle, Las.	1)			18. Moth	ner's Name	(First, Middle,			
Ilc eve	To Be	Arthur Franklin A	sh			F	loren	ce Rebe	cca 1	Baker	
other treumatic		19a. Informant's Name/Relationship Shirley Alessi	(Type, Print) Niece			ess (Street and Numb oine Avenue		Route Number			p Code) 1204
othe		20a. Method of Disposition		20b. Place of cemeter	Disposition (f	Vame of or other place)	Da	ate	20c. Loca	ation - City or T	own, State
ury or		Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Special Control of Control		Morela	ınd Men	orial Pk	8/16/2	2006	Parky	ville,	Maryland
eny Injury or other once.		21. Signature of Funeral Service Lies	in Denter	<del>-</del>	Burge 3631	and Address of Faci e—Henss—Se Falls Road	eitz <u>I</u> d Ba	Tuneral Itimore	Home Mai	e, Inc. ryland	21211
cian	25.00	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	ofte cause on each lin	Ð.		node of dying, such a		respiratory arr	est,		Approximate Interval Between Onset and Death
lical iner		resulting in death)	Due to (or as a	consequence	of):	mgare (13	<u> </u>				
insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence	of):						
e burial-transit	cal Exa	resulting in death) Last	Due to (or as a	consequence	of):						
a as th	Med	IF FEMALE:							T		
d be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 12 Pregnant at 19 Unknown	2 Fetal death	3 □Ectopic 5 □ Other	c pregnancy (specify)			23	3d. Date of deli- Month	very Day Year
tetac	by	Part II. Dther significant conditions	contributing to death bu	t not resulting in	the underlyin	g cause given in Part	I.		bacco use		the cause of death?
pe pe	eted				·		<del></del>				
ed bluod	Completed							24a. Was a autop: perfor	sy	prior to c death?	opsy findings availab ompletion of cause of 2 \square No
page 2 shoul	a	25. Was case referred to medical examiner?	Hospital:	- 5 - 5 - 5		1		(Check only or			
page 2 shoul	100	1 ☐ Yes 2 No	28a. Date of Injur	y 28b. 1	ime of	28c. Injury at		ne 5 Resid 8d. Describe h			ify)
page 2 shoul	To B	27. Manner of Death		rear) li	njury M	Work? 1 Yes 2				Number or Ru	ral Route Number,
page 2 shoul	To B	1 Natural 5 Pending investigate 3 Suicide 6 Could not design to the could not design.	be 28e. Place of Inju	ry - At home, fa	rm, street, fac	tory, orrica		City or Tow	II, State)		
page 2 shoul	Certification: To B	1 Natural 5 Pending Accident investigativ 3 Suicide 6 Could not determine	be 28e. Place of Inju building, etc	. (Specify)			and place, a		ause(s) a	and manner as	stated
ely filled in by the funeral director, page 2 shoul	Certification: To B	1 Natural 5 Pending investigative 3 Surcide 6 Could not determine	be 28e. Place of Inju	. (Specify)  If my knowledge examination an	, death occur	red at the time, date a	and place, a eath occurre	nd due to the o	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)
ely filled in by the funeral director, page 2 shoul	To B	1 Natural 1 Accident 2 Suicide 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying F	28e. Place of Injubulding, etc.  thysician: To the best caminer: On the basis of and manner sta	. (Specify)  If my knowledge examination and	, death occum d/or investigat	red at the time, date a ion, in my opinion, de	ath occurre	nd due to the o	late and p	place, and due	to the cause(s)
funeral director, page 2 shoul	Certification: To B	1 Natural 1 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	28e. Place of Injubulding, etc.  thysician: To the best caminer: On the basis of and manner sta	. (Specify)  If my knowledge examination and	, death occum d/or investigat	red at the time, date a ion, in my opinion, de	ath occurre	nd due to the o	late and p	place, and due	to the cause(s)

State of Maryland / Department of Health and Mental Hygien () [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 14, 7:50 A M Nathaniel Hale Echols, 2006 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral Director** 87 122-10-2654 MAY 12, 1919 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural", or itama 23a or 28a-f show any Injury or other traumatic avent, the Modical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Fusting Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 25 No Specify. δ Specify: Black 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Presser Dry Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah Echols Mattie UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47872 Allegheny Circle Potomac Falls, VA 20165 Nathaniel H. Echols, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/15/06 Baltimore, MD 21. Signature of Funeral Service Licensee
Fdward A Gregorchik M01060 22. Name and Address of Facility Amigone Funeral Home 2600 Sheridan Drive, Tonawanda, NY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BRONCHO PNE UMONIA One week /Medical Due to (or as a consequence of): Examiner year SENILE DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No HYPERTENSION 3 Probably 4 Unknown as been sig Completed CORONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? HRTERY autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) Medi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D. 30469 1100 August 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.B. VBLLANKI, 8850. COLUMBIA 100 BARKWAY : + 308. Columbia: MD. 21045. 31. Date liled (Month, Day, Year) 32. Reistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 1 5 2006

			For State		State of M	aryland .		artment of <i>rtificate of</i>		and Mer		60	06	25560
			Registrar     Decedent's Name	(First, Middle, Las	st)			Timeate of	Dealii	2.	Date of Death	J. No.		3. Time of Death
	Physicia		Anna	June			Εć	lmonds			Month 08/12/2	2006	Year	7:55 P M
	/Medic Examin		4a. Facility Name (If	not institution, give	street and number)			4b. City, Town,	or Location o	of Death		4c. County	of Death	
			809 Scott						Burnie			Ann		undel
B	Funeral Director		5. Social Security Nu 213-30-54	463	ex 7. Ag □M 2⊠F	ge (In yrs. last 72	birthday) Yrs.	Months Days			Date of Birth (Month, Day, ) une 24,	1934	Cou	place (State or Foreign ntry)
	and aw		Usual Residence of 10a. State	10b. County		10c. City, T	own or L	ocation					1	10d. Inside City Limits
	Mary -f •hc	tor	MD	Anne Aru	nde1		G1en	Burnie						1 ☐ Yes 2 XNo
	h the	Director	10e. Street and Num	nber				10f. Zip Code			100	g. Citizen of V	Vhat Cou	ntry?
	238 c	alD	809 Scott	t Circle				210				U.S.A		
036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene 4 Hygiene 6 Hy	by Funeral	11. Marital Status  1 ☐ Never Marrie 3 ☐ Widowed		12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	?	13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No.		gin? (Specify 1, Puerto Rica	y Yes or No- an, etc.)		k, White,	can Indian, etc. nite
Maryland 21215-0036	ithin 72 ho ie. ien "netur	Completed	(Speci	15. Decedent's Edify only highest grandary (0-12)	lucation de completed) College (1-4or	5+)	(Give	edent's Usual Occu e kind of work done DO NOT use retir	e during mos ed)		16	6b. Kind of Bu		dustry
2	led wi	Con	12 17. Father's Name (	Sina Middle ( A)		1	Assi	stant Boo	-		Vant. Adiabatia. Adia	Print		
anc	d be findal Hed of	Be c	unknown	riist, Middie, Last)						known	irst, Middle. Ma	nuen Suman	16/	
2	2 should be and Mental i e marked o aumatic eve	ပ္	19a. Informant's Na	me/Relationship (7	Type, Print)		19b. Mail	ing Address (Stree			oute Number, (	City or Town,	State, Zip	o Code)
S	alth ar 27 io 27 io		Mr. Leroy	B. Edmo	nds / hus	band	809	Scott C:	ircle;	G1en	Burnie	MD 2	1060	
ē,	es 1 a of Hei of Hei r othe		20a. Method of Disp		Removal from State	20b. Plac		osition (Name of ematory or other pl		Date		c. Location -		own, State
Ĕ	Page ment ent: if ury o		4 Donation	5 Other (Specify		Glen		en Mem. I				Glen 1		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any Injury or other traumatic ev <u>pnce</u> .		21. Signature of File	Liogn	- mila	.63		2. Name and Add Second A		-				
			23a. Part1. Enter th	e disease, or comp	plications that cause one cause on each l	d the death. [	Do not en	iter the mode of dy	ying, such as	cardiac or re	spiratory arres	it,		Approximate Interval Between
	Physician		Immediate Cause (I disease or condition	Final n	а.	50	291	t C	meer	~				Onset and Death
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Ö,	icate be executed physicien and s the burial-transit		resulting in death) L	ast	Due to (or as	a consequen	ice of):							
58760,	cate by	edical			d								-	
D. Box 6	Attending Physician: The law requires that the death certific redath.  sctor: Atter this certificate has been signed by the attending is the tuneral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 ⋅ 1 □ Yes 2 □ 9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	□Ectopic pregnan □ Other (specify)	су			23d. Dai Mo	e of deliventh	ery Day Year
P. O.	that the	Phy		icant conditions o	ontributing to death t	out not resulting	ng in the i	underlying cause o	iven in Part I.	. 1	23e. Did toba	cco use cont	ribute to t	he cause of death?
g G	uires sign		Hoza	extresion							1 ☐ Yes	2 🗆 No	3 Prot	bably 4 Unknown
ဂ္ဂ	aw require ss been sig 2 should b	Completed	015	sairure							24a. Was an	24b. \	Were auto	opsy findings available
Re	The lay	шо	H	poo Mono	z da.						autopsy performe 1 Yes 2	ed?	death?	mpletion of cause of 2 No
Ē	ysician: The is certificate h director, page	Bec	25. Was case reference		•				26. Place	of Death (C	heck only one	• • • •		
<u>~</u>	Physic this ce al dire	မ	1 ☐ Yes 2 🔀	- 4	Hospital: 1 ☐ Inpati		/Outpatie	IN JU DOA			5X Residen			<b>(y</b> )
Division of Vital Records,	death. ctor: After the funera	ertification:	27. Manner of Death  1 Natural  2 Accident	5 Pending investigation		ury 28 ay Year)	lb. Time o	W	uryat ork? ∐Yes 2 ☐		l. Describe how	injury occuri	red	
Ď N	s after de si Direct	Certific	3 Suicide 4 Homicide	6 Could not be determined	286. Place of in	jury - At home tc. <i>(Specify)</i>	, farm, si	treet, factory, office	9	28f.	Location (Stre City or Town,		er or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)		ysician: To the best niner: On the basis of and manner st	of examination								
	To th To th compl	Me	29b. Signature and	title of certifier	7. 1.	A.		29c. Lice	nse number	->1		1. Date signe		
)			/	mel	July 1	W			2-402	١٤	Drive Drive	reguest	14,2	2006
	3			ess of person who	completed cause of	death (Item 23	За) (Туре	Print) 323	5 Hos	pital sine,	Drive ND ?	Suit 2006	20	2
	Sta Registi		31. Date filed (Mont	th, Day, Year)	407	rar's Signature	A	have						

			For	State of Maryland	/ Department of Health and I	Mental Hygien	2006 2556I
	6		State     Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. N	3. Time of Death
	Physicia /Medic		HEIEN	FRANCI:	\$	Augus.	+ 13,3ag 8:23 #
	Examin		4a. Facility Name (If not institution, give	EDICAL CE	4b. City, Town, or Location of Death	she l	c. County of Death
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent  10a, State  10b, County	10c City T	Fown or Location	1119041	10d. Inside City Limits
	Marylar I shov	tor	md. Tob. County	1A	Battemore		1 Yes 2 □ No
	with the	Director	10e. Street and Number	1 + Ct. not	515 10f. Zip Code	10g. C	Citizen of What Country?
	death very series and series are series and	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturs!", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed Divorced	1 ☐ Yes 2 ♠No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
15-0036	n 72 hor	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b.	Kind of Business/Industry
2121	filed within Hygiene. other than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Court Cle	rk	City
and	ould be filed Mental Hygi arked other atic event, I	To Be	17. Father's Name (First, Middle, Last)	White SR.	18. Mother's Nar	ne (First, Middle, Maide	( oleman
Mary	2 should and Men is marke eumatic	F	19a. Informant's Name/Relationship (T)	C - To	19b. Mailing Address (Street and Number or Ru	0.4.2	
e,	Health tem 27 other tr		20a. Method of Disposition	20b. Place	es of Disposition (Name of letery, crematory or other place)	Date 20c.	Location - City or Town, State
altimor	Page nent o ant: If ary or		t	Removal from State	: Zion Cem. 8-		insdring, md.
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Ucens	ny	22. Name and Address of Facility	Fune al H	Pass ane Balto, md. 21229
8	*		shock, or heart failure. List only o	lications that caused the death. ne caus , on , ch line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
)	Pnysician /Medical		Immediate use (Final disease or Indition resulting in death)	a. A COOR	CHACAC	54100	Word France
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	Hy artory	MSE	DASE YEARS
Г	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Hyper	TUSION		YEAR
8760,	ate be executed hysician and the burial-transit	al Ex	resulting in death) Last	Due to (or s a consequer	nce of):		
9	rtificate ng phys	Medic	IF FEMALE:	u			
Box	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deal	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O.	d by the	Phys	9 Unknown	9 Unknown	ng in the underlying cause given in Part I.	23e Did tobacc	o use contribute to the cause of death?
	v requires ti been signe should be c	þ	ratti. Otter significant conditions of	Third thing to death but not result		1 ☐ Yes	<b>.</b>
Seco.	e law requir has been si le 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal	sicien: The lav certificate has rector, page 2	Be Col	25. Was case referred to medical		26. Place of De	1 Yes 2 4 1 ath (Check only one)	No 1 Yes 2 No
ζV	Physicien: r this certific ral director,	2	THE THE ZUINO			fome 5 ☐ Residence	
ono	Attending P r death. ector: After t	tlon:	27. Manner of Death 1. Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Division of Vital Records,	or Atter after dea Director in by the	rtifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
_	To the Hospital or Attending Physicien: The within 24 hours after death. Yo the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Certification;			edge, death occurred at the time, date and place n and/or investigation, in my opinion, death occ		
	To the To the Comple	Me	29b. Signature and title of certifier	Cran	29c. License number	29d. I	Date signed (Month, Day, Year)
			30. Name and address of person who	completed cause of death (Item 2	13a) (Type, Print) KAISCIA A CI	MU HU	19US+ 13, 2006
	7/		301 St. Pa	ul Place	Baltmore	MAG	1AND 21202
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	11 hourse		
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State of Maryland / Department of Health and Mental Hygions  For Date  For D	06-05960							in Black Ind				
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Hardon Hospital Center   Baltimore   Bal	Medical Examin							141 011 7				
Security Number   Security N					street and number)				or Location of	Death	,	n
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Physician (Medical Examinor)    Part   Committed   Physician (Medical Examinor)   Part   Committed   Part   Part	E F P E		bum &	Schl	angu	ب		299 Frede	rick R	oad Baltim	ore, MD 212	228
memodate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  Sequentially list conditions.			23a Part I. Enter the dise	ease, or compli	ications that caused	the death	. Do not e	nter the mode of dyin	ng, such as car	rdiac or respiratory arre	est, shock, or heart	
Due to (or as a consequence of):    Condition Resulting in death)   Condition			Immediate Cause (Final	disease a.		heroscl	lerotic (	Cardiovascular D	Disease			
Due to (or as a consequence of):	1		or condition resulting in o	leath) [	Due to (or as a conse	quence o	of):					
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The property of the property o	,	ij	cause. Enter Underlying	Cause c								
The property of the property o	1 git	Exal			Due to (or as a conse	quence o	of):					
FEMALE:   23. Was decedent pregnant in the past 12 months?   23. Bet of delivery   23. Date of delivery   23. Da	xecut		LINDENDED	d	AMENDED							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No   25b. Was case referred to medical examiner?   1   Yes 2   No   25b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   1   Yes 2   No   25c. Injury at Work?   28d. Describe how injury occurred   1   Yes 2   No   25c. Injury at Work?   28d. Describe how injury occurred   26c. Place of Injury - At home, farm, street, factory, office building, etc.   26f. Location (Street and Number or Rural Route Number, City or Town, State)   25c. Injury and the time, date and place, and due to the cause(s) and manner as started.   25c. Licease number   25c. Licease number	so, te be o					o of prog					22d Date of delive	
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29b. Signeture and fitle of certifier  29c. License number O.C.M.E.  29d. Date signed (Month, Day, Year) August 12, 2006  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year) 32. I gistrar's Signature 32. I gistrar's Signature	Bo e deal the al	hys	1 Yes 2 No 9	Unknown	9 Unknown							
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Separation   Sep	1 🗹 Yes 2 ☐ No 10g. Citizen of What Country?
Security   Specify   Spe	o- 14. Race - American Indian,
South   Sout	20 M
17. Fallers Name (First, Middle, Last)   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number or Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number of Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number of Rural Route Number, City or Town, Safe, 15   19. Mailing Address (Street and Number of Rural Route Number, City or Town, Safe, 15   19	16b. Kind of Business/Industry
The part of the pa	
20. Mathod of Disposition    Burial 2   Diremation 3   Removal from State	ridding
Comparison   Secretarian   Comparison   Co	Indelphia, PA. 19130
Physician / Medical Examiner  Physic	Catorsville md,
23a. Plant 1. Enter Medical Examiner  Physician / Medical Examiner	Sen. Back. nd, 21229
Medical Examiner  To Brown and the past 12 promises a consequence of):  Due to (or as a consequence of):  MORGINE DEPTH Causes (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a	rrest, Approximate Interval Between Onset and Death
Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last    Proposed Cause (Disease or injury that imitiated events resulting in death) Last    Proposed Cause (Disease or injury that imitiated events resulting in death) Last    Proposed Cause (Disease or injury that imitiated events resulting in death) Last    Proposed Cause (Disease or injury that imitiated events resulting in death) Last    Proposed Cause (Disease or injury that imitiated events resulting in death) Last    Proposed Cause (Disease or injury that imitiated events resulting in death) Last    Proposed Cause (Disease or injury that imitiated events resulting in the underlying cause given in Part I.   23d. Date of death   23d. Date of Date   23d.	
That initiated events resulting in death) Last    Due to (or as a consequence of):  Due to (or as a conseque	
Section   Sect	
25. Was case referred to medical examiner?  1   Yes   2   To   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specific Regions)   28b. Time of   28c. Injury at   28d. Describe how injury occurred   World   Wo	
25. Was case referred to medical examiner?  1   Yes   2   To   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specific Regions)   28b. Time of   28c. Injury at   28d. Describe how injury occurred   World   Wo	
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25. Was case referred to medical examiner?  1   Yes   2   To   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specific Regions)   28b. Time of   28c. Injury at   28d. Describe how injury occurred   World   Wo	tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
25. Was case referred to medical examiner?  1   Yes   2   To   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specific Regions)   28b. Time of   28c. Injury at   28d. Describe how injury occurred   World   Wo	psy prior to completion of cause of
examiner?    The control of the cont	2 No 1 Yes 2 No
27. Manner of D ath   27. Manner of D ath   28a. Date of Injury	
Section   Street and Number or Record   Street and Number or Rec	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
2000	Street and Number or Rural Route Number, wn, State)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month	cause(s) and manner as stated. date and place, and due to the cause(s)
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month	29d. Date signed (Month, Day, Year)  August 11 7006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	BAST MD
3 1000 0 0000	0.11
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature  DHMH 17 Rev 1/2001	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 4:00 AM. **Physician** KENNETH 2006 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner University of Maryland Medical Center 21201 N/A Baltimore, MD 8. Date of Birth (Month, Day, Yea Aug. 23, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex. 1 ☑ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Days Hours 65 194d 214-38-5813 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a State 10b County 10c. City, Town or Location 77 is marked other than "naturel", or items 23a or 28a-1 show treumatic event, the Medical Examiner must be notified at 1 TYes 2 No Director Harford Pvlesville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21132 1615 Scott Rd. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after dealt Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto/Truck Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fick Sr. Sadie Rothhaupt Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7843 Bodkin View Dr. Pasadena, Md. 21122 Pamela Swaggerty (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8/12/06 Baltimore, Md. Metro Crematory Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stallings Funeral Home PA 21. Signature of Funeral Service Licentee 3111 Mountain RD. Pasadena, Md. 21122 23a. Part1. Enter the discase, or complications that mused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the muse of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) endocarditis eight weeks Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ➤ No 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 No certificate After this certification, funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2'No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie P# 15859 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland South Greene Street 22 MD Robert Davidson 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

**ORIGINAL** 

				State of Marylar		nt of Health and		iene,	
			For State Ragistrar	,	•	te of Death		eg. No UUO	25565
	Physici	an	1. Decedent's Name (First, Middle, Last	o R	CI	BEDT	2. Date of Deat	Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	street and number)	4b. Cit	, Town, or Location of Dea	th 1-10gusi	4c. County of Deat	
	LAMIIII	ja Ja	3323 Raveny	vood Avenu	e 30	altimore		1	1/A
	Funeral Director		X17-26 6011	x 7. Age (In yrs.	1 Yrs. If Und Months	er 1 Year If Under 24 Hrs Days Hours Min		(1929 9. Birt	hplace (State or Foreign untry)  ARYLAND
1	yland		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
1	ours after death with the Maryland ral', or Items 23a or 28a-f ahow Examinar must be notified at	Funeral Director	MARYLAND Number	IA	5	ALTIHOR ip Code		0g. Citizen of What Co	Yes 2 No
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20	tems a	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Dec If Yes, sp	edent of Hispanic Origin? (secify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
036	n 72 hours after death wi "naturel", or Items 23a edicel Examiner must b	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	t □Yes 2 X No tt Yes, Give Year or Dates:	1 ☐ Yes	2. No Specify:		Specify: 13/	ACK
اج اج-20036	"natur	Completed	15. Decedent's Edu (Specify only highest grad	ucation le com <i>pleted)</i>	16a. Decedent's Us (Give kind of w life. DO NOT	rork done during most of wo	orking	16b. Kind of Business/	Industry
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ris and 2	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)	D	- (		me (First, Middle, I		1,400,100
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$\mathcal{C}_{\mathcal{A}}$ Maryl	nd 2 st lith and 27 Is n r traun		19a. Informant's Name/Relationship (7)	BFRT (SON)	) 2610	ss (Street and Number or F	SCO AVE	APT 7 CBA	HD. MA 51.23
Baltimore,	of Health of Health fitem 27 r other tra		20a. Method of Disposition  1 8 Burial 2 Cremation 3 1		Place of Disposition (N cemetery, crematory or	ame of other place)		20c. Location - City or	Town, State
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Bal	Depar Depar Impor		21. Signature of Funeral Service Licens	D/00	To Sook	and Address of Facility 2	Tr. Funen	al Home B	altimore
Ŷ			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not enter the me	ode of dying, such as cardia	ac or respiratory arre		Approximate Interval Between
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x 68	ertifica ding ph	Med	IF FEMALE:	23c. If yes, outcome of pregn					
Во	death c	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6	al death 3 □Ectopic			23d. Date of del Month	ivery Day Year
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Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica cleath. Geath. ector: After this certificete has been signed by the attending ph by the funeral director, page 2 should be deteched for use as th	d by	Part II. Other significant conditions co	ntnbuting to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tot	oacco use contribute to es 2√No 3□Pr	othe cause of death?
lose	e law req has beer je 2 shou	Completed					24a. Was a autops	n 24b. Were au	itopsy findings available completion of cause of
E E	ding Physician: The I h. After this certificete ha funeral director, page	Com					perform	ned? death?	2□ No
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	Hospite 24 hours Funere tely fille	lical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kn	owledge, death occurre ation and/or investigation	d at the lime, date and place on, in my opinion, death occ	ce, and due to the courred at the time, do	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	ro the vithin 2 ro the comple	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License number	2	9d. Date signed (Monti	h. Day, Year)
	C > F 0		> lund			D29071		8.11.200	6
	6		39 Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type, Print)	D29071 474W ST	BALT	MARE	-MO2121
	Sta		31. Date filed (Month, Day, Year)	32. Abgistrar's Sign	lature Results	1	0.1.	1	, (
4	Registi	rar	AUG 1 5 20	UU R. BEERSON	JUST SERVICE				

		State of Maryland / Department	artment of Health and Martificate of Death		ené () () () ()	25567
Physicia		1. Decedent's Name (First, Middle, Last)  Janet K. Grayson		2. Date of Death	f3, 2006	3. Time of Death 12:24 PM
/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Death	n	4c. County of Death Balt	imore
Funeral Director		5. Social Security Number 6. Sex 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day April 02	9. Birthp 9. Birthp Count 1924 Maryl	lace (State or Foreign try) and
Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  Maryland Baltimore County Luthervi			1	0d. Inside City Limits 1 ☐ Yes 2 🛣No
h with the 3a or 28a	Funeral Director	10e. Street and Number 831 Jamieson Road	10f. Zip Code 21093		g. Citizen of What Coun United Stat	•
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene.  Department of Heelth and Mental Hygiene.  Department of Heelth and Mental Hygiene.  Department of the Trian and Mental Hygiene.  Department of the Trian and Mental Hygiene.  Department of the Trian And Trian Medical Examination of the notified at Once.	by	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecrfy Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
within 72 ho ene. then "netu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)  ACCOUNTANT	ing	6b. Kind of Business/Ind Accounti	
ld be filed ental Hygi kad other ic event, 1	To Be Co	17. Father's Name (First, Middle, Last) Grover Keller	18. Mother's Name			
and 2 should be eeith and Mental m 27 is marked oner treumatic even			ng Address (Street and Number or Rura Jamieson Road L		City or Town, State, Zip le, Marylan	
Pages 1 and of Heemont: If item		4 Donation 5 Other (Specify)	natory or other place) neral Chapel Aug.1	8,2006	Oc. Location - City or To Forest Hill	,Maryland
permit. Departminement importations any injurity		21. Signature of Funeral Service Licensee L. Jaw. 1. 22	2. Name and Address of Facility Pacceful Alternative 325 York Road Til	es Funera monium, I	al&Crematio Maryland	n Ctr.,P.A. 21093
The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Exter the disease, of complications that clused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  ASYSTOLE  Due to (or as a consequence of):  Due to (or as a consequence of):  MYDCARDIAL INFO  Due to (or as a consequence of):	Y DISEASE	or respiratory arres	st.	Approximate Interval Between Onset and Death
that the death certificated by the ettending p	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
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ysiciar ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🗶 No Hospital: 1 ☐ Inpatient 2 💆 ER/Outpatier	Other	h <i>(Check only one</i> me 5 ☐ Resider	nce 6 Other (Specifi	v)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has gompletely filled in by the funeral director, page 2	Certification:	27 Manner of Death  1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how		
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the Hos nin 24 ho the Fun npletely t	ledical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deat control on the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	red at the time, da	te and place, and due to	the cause(s)
S S S S S S S S S S S S S S S S S S S	Σ	29b. Signature and title of certifier	D 46356	Å	d. Date signed/Month, up UST 13	, 2006
12,		30. Name and address of person who completed cause of death (Item 23a) (Type, KHOSROW TABASSI, M.D., 7601 OS		ON, MAR	YLAND 218	204
Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 5 2006  32. Registrar's Signature	bouli			

			For State Registrar	State of Marylan		artment of F			iene 19. No.2 0 0 (	25568
			1. Decedent's Name (First, Middle,	ast)		7		2. Date of Deat Month	h Day Year	3. Time of Death
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,	Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	r-Location of Death		4c. County of De	ath
			The Johns Hopk			10	OVZ If Under 24 Hrs.	1	N/A	
	Funeral			. Sex   1	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) (	inthplace (State or Foreign Country)
	Director		215-12-8441 Usual Residence of Decedent	χ 03				Aug 26,	1922 M	aryland
500	Mod		10a. State 10b. County	10c. Cit	, Town or Lo	cation				10d. Inside City Limits
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ď	or 28	irec	10e. Street and Number			10f. Zip Code	-	11	0g. Citizen of What 0	Country?
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à	tem meri	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	io.	by F	1 ☐ Never Married 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	d 1 XiYes 2 ☐ No If Yes, Give WW2 Year or Dates: WW2	2	1 ☐ Yes 2 📉 No	Specify:		Specify: [	White
11215-0036	al E	ed	15. Decedent's			dent's Usual Occup			16b. Kind of Busines	s/Industry
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פ	oth of	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
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Maryland 21215-0036	is m		19a. Informant's Name/Relationship						City or Town, State	·
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Baltimore,	perint. Tays: I and a stoom be lighted with 7 a hours after death with the wayner begattening the falls and Mental Higher. I figure in the many solutions at 1 and 127 is marked other then "neturel; or lieme 23a or 28a-1 ehow any njury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 Sparial 2 □ Cremation 3	Homovai iloni State		sition (Name of matory or other pla	1		20c. Location - City o	
tim	rtent		4 ☐Donation 5 ☐ Other (Spe			's Ch Cer		1//2006	Homeland,	Balto, MD
Bal	de d		21. Signature of Fundal Service Co	Lawron	24	Mitchell-	-Wiedefe1	d Funera	1 Home, In	nc.
			Martin D. La	WSON	n. Do not ent	6500 Yorl	Road, B	altimore	<del>, Marylan</del> o	1 21212 Approximate
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39	ing pt	Physician/Med	IF FEMALE:							
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ecords, P.O	signed by the e		Part II. Other significant condition	s contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
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Re	0 2 0	Ę						autops perforr	y prior to ned? death'	completion of cause of
_ `	certificete	ပ္	25. Was case referred to medical	-			26 Place of Don	1 ☐ Yes 2 th (Check only on	-	es 2 No
>		To B	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 Hopatient 2 -	ER/Outpatier	nt 3 DOA Ott	ner .		ence 6 ⊡Other (Sp	necify)
			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	
Division	r death. ctor: After of the funeral	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	injury		Yes 2 □No			
ivis	er de recto	ti Eile	3 Suicide 6 Could no 4 Homicide determin		ome, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or . n, State)	Aural Route Number,
۵	rs afte	Se								
1	within 24 hours after deall To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical Ex	Physician: To the bast of my kno kaminer: On the basis of examina	wladge, deat tion and/or in	froctured at the ti vestigation, in my	me date and plane opinion, death occu	and due to the or rred at the time, d	ause(s) and manner ate and place, and d	ue to the cause(s)
	within 2 To the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	sa number	1 2	9d. Date signed (Mo	nth. Day. Year)
<b>)</b>	× × 0									
	7)		30. Name and address of person w	ho completed cause of death (Item	n 22a\ /7		5-000		Whist 13	5,000
	8		So. Name and address or person w	no combined cause of death (item			20 St 1 72	2115	MAZIZ	3 7-
1	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signe	ture	A S	6 3 West 1	and work	,3 = 1 =	· · · · · · · · · · · · · · · · · · ·
	Regist		AUG 1 5 21	006	- FARE	7-5/2				

State of Maryland / Department of Health and Mental Hygiene 1- State Amend item#10a, perFH, g858, 8/15/06 TT Certificate of Death Rég. No. 🦾 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 1:05 a M 11,2006 CAROL GOODLIN L. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TOWSON

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year DEC. 25, GILCHRIST CENTER FOR HOSPICE BALTIMORE 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 5,1941 1 ☐ M 2 🖫 F Yrs. MARYLAND Director 219-26-9393 64 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehov traumatic event, the Madical Examiner must be notified a XXYes 2 □ No Directo MD. BALTIMORE 10e. Street and Number 2613 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if them 27 ie marked other than "not not not traumette".

• or y injury or other traumette. ö items 23a @ # # FAIT AVENUE 21224 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GivaX Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XIXNo Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MANAGER RITE AID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN EMMEL MARIAN CAWTHORNE ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KENNETH GOODLIN/HUSBAND 2613 FAIT AVENUE BALTIMORE MARYLAND 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Nation 3 ☐ Removal from State OAK LAWN CEMETERY 8/14/06 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundant School Licensee 22. Name and Address of Facility
LILLY & ZEILER INC FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cancer menters disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sicion and burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sete has been signed page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certification, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🕳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier August 11, 2006 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Bolts Md Zizos R: BMC 6701 6 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 5 2006 Registrar

			For State	State of Marylan		rtment of l		•		2006	255	70
			Registrar  1. Decedent's Name (First, Middle, Last)		061	illicate of	Deain	2. Date of De	Reg. No.	.000	3. Time of D	) O
	Physicia /Medic		Chery 1			Jorna	N	Aways	Day	2006	23:02	
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Dea	ath	4c. (	County of Deat	n	
				opkins Itosp	ital	Baltin	nore C	ity		N/A		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hi Hours Mil	8. Date of Bir (Month, Da	th y, Year)	9. Birti Co	nplace (State or untry)	Foreign
	Director		210-32-3009	M 201 57	Yrs.			SEPT.	[2,19]	948WAS	HINGTO	N,D.
	Due A	1	Usuat Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Loc	cation					10d. Inside City	Limits
	Mary!	5	FLORIDA N/A				e a Cu				1 ☐ Yes	
	26a-1	Director	10e. Street and Number		OKT M	YERS B	LACH		10a Citis	en of What Co		
3	deeth with the Maryland rme 23a or 28a-f ehow r nust be politied	ā	17105 A-6 SAN C	ADIOC DOUL	בו מו אוזים		0.2.1	į			unity :	
	ne 23	Funeral		2. Was Decedent Ever in U			931 Hispanic Origin?	Specify Yes or No		S.A.	rican Indian	
	r iten	필	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo	II	Yes, specify Cub	an, Mexican, Pue	erto Rican, etc.)		Black, White		
Š	urs a	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:			Specify: W	HITE	
5	should be filed within 72 hours after deeth with the Marylan and Mentel Hygiene. In adverted other then "naturel", or iteme 23a or 28a-f ehow marked other then "naturel" or iteme 23a or 28a-f ehow martic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ		16a. Deced	ent's Usual Occu	pation		16b. Kir	d of Business/	industry	
	L L	e d	(Specify only highest grade Elementary/Secondary (0-12)	Cottege (1-4or 5+)	life. D	kind of work done OO NOT use retire	during most of word)	rorking				
7	giene.	Ö	, , , , , , , , , , , , , , , , , , , ,	1		OWNER			RES	STAURA	NT	
2	of Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	Maiden :	Sumame)		
9	should be filed within the Mentel Hygiene. marked other then imatic event, the Mentel Hygiene.	၉	BERNARD ZABR	EK			CYNT	HIA PA	LDE	₹		
9	and ie mu		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Stree	t and Number or I	Rural Route Numb	er, City or	Town, State, Z	(ip Code) 33	931
Σ.	5 € Z ±		KENNETH GORMAN/H	USBAND	17105	A-6 S	AN CARL	OS BLVD	.,F7	.MYER	S BEAC	H,FL
. עב	of Hee		20a. Method of Disposition t ☐ Burial 2 ☐ Cremation 3 ☐ Re			sition (Name of natory or other pla	ice)	Date	20c. Loc	cation - City or	Town, State	
Ĕ	Pages nent of ant: if it ury or o		4 Donation 5 Other (Specify)		YVIEW	CREMATO	ORY 8/1	5/06	BALT	IMORE	, MARYL	AND
Dallillo	permit. Pages Depertment of the important: if ite any injury or of once.		21. Signature of Function Service License	· 1		Name and Addr	ess of Facility	TNC E			•	
۵	8858		Che mo	1 Tour	<b>/</b>	9614EX	STERNTA	VENUE, E	XĽŤ	MORE,	MD. 21:	231
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat	th. Do not ente	er the mode of dy	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between	een
F	hysician		Immediate Cause (Final disease or condition		Sensi	5					Onset and De	
	/Medical		resulting in death)	Fungal Due to (or as a consec	uence of):	<u> </u>					2900	>
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	ocuted nd rrans	Examin	Cause (Disease or injury that initiated events	anuric 1		failure					3 week	-5
Š	e exe		resulting in death) Last	Due to (or as a consec	uence ol):							
0/0	The law requires that the death certificate be executed its has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dlcal	<b>€</b> d									
Ď	ing pl	Med	IF FEMALE:									$\overline{}$
<b>X</b> 0	ith ce	Physician/Me	23b. Was decedent pregnant in the past 12 menths?	3c. If yes, outcome of pregna 1☐Live birth 2☐Feta		Ectopic pregnanc	ry .		2	3d. Date of deli Month	•	
	the al	200	1 ☐ Yes 2 No	4☐Pregnant at time of o 9☐Unknown	leath 5	Other (specify) _	-			Month	Day Ye	ear
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cords,	neen s	ted						. 10	Yes 25	No 3□Pr	obably 4 Un	iknown
ນ	law lasb	Completed						24a. Was		24b. Were au	topsy findings av	/ailable use of
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<u>.</u>	sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as	Be	25. Was case referred to medical examiner?				26. Place of D	eath (Check only	one)			
	hysi hiso	ပ္	1 □ Yes 2 No		ER/Outpatient	t 3□ DOA Ot	her: 4 Nursing	Home 5 ☐ Resi	dence 6	□Other (Spec	city)	
=	ng P ster t	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	iry at	28d. Describe	how injury	occurred		
20 7	eath.	Certification:	2 Accident investigation			M 1	]Yes 2 □No					
DIVISION OF	irect irect	Ħ.	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	et, lactory, office		28f. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Numbe	9 <i>r</i> .
ָ	To the Hospital or Attending Physician: thin 24 hours alter death To the Funeral Director: After this certifica completely filled in by the funeral director,											
	Hosp 4 hos Fune ely fi	edical	(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina	owledge, death	occurred at the trestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time.	cause(s) date and	and manner as place, and due	stated, to the cause(s)	
	the I	Med	one)	and manner stated.		77						
	T vit	=	29b. Signature and title of certifier	- Mari	. I had		se number			signed (Montl		
	1.		- Ingue			or R	62-00	1	1454	15/	200C	
	10		30. Name and address of person who come Miguel Muñoz, T	mpleted cause of death (Ite	m 23a) (Type, I	Print)	1 ( as Na	M Walls	Stro	et Roll	mere Now	land 200
				32 Benintarda Sian	opens	HUSP. ta	1,600 100	Th VUGITE	3110	, , , , , , , , , , , , , , , , , , , ,	111.411	
	Sta		31. Date lited (Month, Day, Year)	32. Registrar's Signa	L A	and a						

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:30 PM M August 8, 2006 ar Physician Robert Gundlach /Medical a. Facility Name (If not institution, give street and number)

Prince Georges County Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince Georges (In yrs. last birthday) Birthplace (State or Foreign NY
 Ountry) 5. Social Security Number 6. Sex 7. Age If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 € M 2 □ F 0371071916 132-09-1900 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County I Hygiene. other than "natural", or Itama 23e or 28e-1 en∪m vant, the Medical Exerciper roual be notified at MD Prince Georges 1 ☐ Yes 2 No Bowie Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721-USA 10450 Lottsford Rd. permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Moulcal Exemitment and injury or other traumatic event, the Moulcal Exemitment and by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ⊠Yes 2 □ No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1942-1946 Specify: Specify: White 3 □ Widowed 4 □ Divorced Completed t6b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) Film Elementary/Secondary (0-12) Scenic Designer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brutus Gundlach Adele Heubach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite Gundlach/Wife 10450 Lottsford Rd. Bowie, MD 20721-Date Aug 12 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificete 1 Yes 2 \ No 1 Yes 2 No ours after death. laral Diractor: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation J ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funaral L To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifies and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number D58182 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 GEORGE DONALD

State Registrar Registrar's Signature

			1 - For State Registrar	-	epartment of Health and N Certificate of Death	Mental Hygie	4000	25572	
	Physici	an	1. Decedent's Name (First, Middle, Las			2. Date of Death Month	Day Year	3. Time of Death	
	/Medic	ai	4a. Facility Name (If not institution, give	rcu M	4b. City. Town, or Location of Death	ob t	4c. County of Death	10:48 M	
	Examin	er	1.0	OWWOOD AVENU	E BALTIHOR		N/	A	
	Funeral Director		5. Social Security Number 6. Se 219 - 22 - 2798	x 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay, Ye	9. Birthp Coun	place (State or Foreign stry)	
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		1	0d. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow ship injury or other traumatic event. I'm Medical Evantral must be notified at ance.	Director	MARYLAND  10e. Street and Number	IA	BALTIMORE 101. Zip Code	CITY	Citizen of What Coun	1 X Yes 2 □ No	
	th with		4800 YELL	WWOOD AVEN	UE 2120	19	USA,		
	lteme lteme	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,		
5-0036	urs aft	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💆 Divorced	1	1 ☐ Yes 2 No Specify:		Specify: BL	ACK	
	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work	king 16b	. Kind of Business/Inc	dustry	
2121	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)  DO MESTIC (1)	ORKER F	RIVATE	FAMILIES	
	al Hygi I other	BeC	17. Father's Name (First, Middle, Last)	.0	18. Mother's Nam	e (First, Middle, Maid			
Maryland	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other then "naturel", or items aumatic event. If a Madical Examinar m	To	JAMES  19a. Informant's Name/Relationship (7)	10LAC	Mailing Address (Street and Number or Ru.	N Pouto Number Ci	RIC	E	
Ma	and 2 sl eaith and m 27 is r her traur		FAITH BLACKWE	LL (NEICE) 2	002 Wood AW		BALTO,	MD 21207	
ore,	of Hez of Hez if Item ir othe		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆	20b. Place of cemetery	r, crematory or other place)	Date 2 c	c. Location - City or To		
Baltimore	permit. Pag Department Importent: I eny injury o		4 □ Donation 5 □ Other (Specify	MACEDON,	A BAPTIST CHR DEME 08 -				
Bal	permit. Departr Import. eny inju		21. Signature of Funeral Service Licen	book	JOSEPHA . S	AVB.	R. FUNE	10. 21217	
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between						
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9		Medi	IF FEMALE:						
Вох	death ce e attend ed for us	cian/	in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year	
P.O.	ng Physician: The law requires that the ther this certificate has been signed by the there interest director, page 2 should be detach	Physician/Medical	1 ☐ Yes 2 ☐ 100 9 ☐ Unknown	9□ Unknown					
							o use contribute to the cause of death?		
		Completed by	7 - 6.		, c. yeise	24a. Was an	24b. Were auto	psy findings available	
Re		dmo:				autopsy performed 1 ☐ Yes 2 ☑	death?	mpletion of cause of 2 ☐ No	
Division of Vital Records,		Be	25. Was case referred to medical examiner?	Hospital:		th (Check only one)			
		7: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M  28c. Injury at Work?  1  Yes 2 No			e 5 ☐ Residence 6 ☐ Other (Specify)  Bd. Describe how injury occurred		
		ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident Investigation						
Sivis	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura Itate)	al Route Number,	
J	To the Hospital or Attendl within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Ce	29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
	ithin 2 o the omplet	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month,	Day, Year)	
	F > F 0		> Kerri K	isself	P18604	C	14/2	2006	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kerri Kussell 22 S. Greene St. Baltimore, MD  State Registrar  31. Date filed (Month, Day, Year)  AUG 15 2006  32. Sistrar's Signature  AUG 15 2006							D		
	Sta	at <u>e</u>	31. Date filed (Month, Day, Year) AUG 15 21	32. sistrar's Signature	7		-/ 11		
100	Regist	rar	AUG 1 5 Z	Julius St.	Sparks)				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle 2. Date of Death **Physician** an AUGUST 11, 2006 4:32 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 213-94-7980 1**X**M 2□ F Days Min Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show ltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **K**o ģ 3 ☐ Widowed 4 ☐ Divorced Completed 17 is marked other than "nature traumatic event, it is Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i 20b. lace of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important; If any injury or once. 6-06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of all shock, or heart failure. List only one cause on each line. ing, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of) Examiner PNEUMONITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physicien and d be detached for use as the burial-transit RESPIRATORY FAILURE Due to (or as a consequence of): ADULT RESPIRATORY DISTRESS SYNDROME Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ANOXIC ENCEPHALOPATHY 2 No 1 TYes 3 Probably 4 Unknown Completed RENAL FAILURE 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s LACTIC ACIDOSIS 2 No 1 Yes 1 Yes : After this certification at the state of t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W D 31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINTHICUM, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 RICHARD L. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

UNI

K UNK	•	State of Maryland / De	epartme			ygiene		
Physici		1- For State Registrar 1. Decedent's Name (First, Middle,Last)		nte of Death		2. Date of Death		6 255 3. Time of Death
edical Exami	iner	Creil thank Henry	Cecil	Eugene Saunder		Month August 9, 2		0407 hrs
		4a. Facility Name (if not institution, give street and number) 3600 Pulaski Highway		Baltimore	Location of Death	1	4c County of Deat	h
Funeral Director		218.92.9872 1×M 20F	yrs last birth	Months Day		<b>⊣</b>	Forei	rthplace (State or gn VA
ow any		Usual Residence of Decedent  10a State  10b. County  10c. 1	City, Town o	ltinore				10d Inside City Limits
ith the Maryland 123a or 28a-f show notified at once.	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	1 XYes 2 No
vith the s s 23a or		924 Webb Court  11. Marital Status 12. Was Decedent Ever	in II S	2.1  13. Was Decedent of Hi	202	Decify Vos or No	USA	San India Dial
215-0036  be filed within 72 hours after death with the Maryland nutal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married 1 Yes 2 No Norbal Married 2 Married 1 Yes 2 No Norbal Married 1 Yes 2 No Norbal Married 1 Yes 2 No Norbal Married 1 Yes (Sieve Year or Dates:	No	If Yes, specify Cubai	n, Mexican, Puerto		White, etc.  Specify: B	rican Indian, Black,
16 n 72 hours nan "natur ical Exam	Completed I	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College (1-4 or 5+)		ecedent's Usual Occupa uring most of working life	e. DO NOT use reti	vork done red)	16b. Kind of Business	
5-0036 Hed within 72 Hygiene I other than		17 Father's Name (First, Middle, Last)	i	Coo	18.Mother's Name	(First, Middle, M		
2 블롱롤리	To Be	19a. Informant's Name/Relationship (Type, Print)	19b	Mailing Address (Street	et and Number of F	Paral Route Numb	Der, City or Town, State	e, Zip Code)
e, MD and 2 shot lealth and 1 irem 27 is transmatic		Peggy Henry/Mother 20a. Mathediat Disposition 2	20b. Place of	24-Webb Disposition (Name of ce		Baltim	ore MD 2  20c. Location - City or	21202 Town State
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify	GVe			14.06	Baltm	4 -
Ball permit Depart Impor		21. Signature of Funeral Service Licensee  Roll 1 Mol363		23 Name and Addres		uneral S	sentices per MD 21:	212
Physician /Medical		23a. Fart I. Enter the discase, or complications that caused the de failure. List only one cause on each line		enter the mode of dying,	such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence)						
	miner	if any, leading to immediate cause. Enter Underlying Cause	nce of):					
xecuted and ransit	Exa	events resulting in death) Last  Due to (or as a consequence of the co	nce of):			<del></del>		
rial	edical	UNPENDED X AMENDED #1,perl	ME,g860	, 10/25/06 TT				
Records, P.O. Box 68760, The law requires that the death certificate b cate has been signed by the attending physicage 2 should be detached for use as the but	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of public past 12 months?  23c. If yes, outcome of public past 12 months?	pregnancy 2	Fetal death 3 Other (Specify)	Ectopic pregna	ncy	23d Date of deliver Month	y Day <b>Y</b> ear
P.O. Best hat the degree by the educached f	Phy	Part II. Other significant conditions contributing to death but n	not resulting	in the underlying cause g	given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ords, P.C.  v requires that s been signed!	ted by		_			1 Yes	2 No 3 Prol	pably 4 Unknown
	Completed	25 W				autops perform 1 ✓ Yes 2	y prior to oned? death?	completion of cause of
Vital ysician his cert directo	o Be	25 Was case referred to medical examiner?  — 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2	ER/Out	26.Place	Other Nursin		Residence 6 🗸 Othe	r: Scene
ion tendin eath for: A	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a Date of Injury FOUND: Day Year) Aug 9, 2006	28b T FOUN 0358	ND: 1	ry at Work? Yes 2  No	28d. Describe ho Subject was	ow injury occurred beaten	
:> p q q ig ii	Certification;		At home, far	m, street, factory, office b		or Town, Sta	reet and Number or Ru ate) Highway, Baltim	ore, MD
To the Hospital within 24 hours. To the Funeral completely filled	Medical (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	wledge, deat ion and/or in	h occurred at the time, divestigation, in my opinion	ate and place, and n, death occurred a	due to the cause t the time, date a	(s) and manner as star nd place, and due to th	ted e cause(s)
F × = 3	M	29b. Signature and title of certifier		29c. Licens			29d Date signed (Mo	nth, Day, Year)
		Family Withauly Man 30. Name and dedress of person who completed cause of death (	(Item 23a)	O.C.	M.E.		August 9, 2006	
\		Pamela Southall, MD Assistant Medical Exa	aminer	111 Penn Street, E	Baltimore, MD	21201		
St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	Spende				

DHMH 17 Rev 1/2001

**ORIGINAL** 

		ŀ	1 - For State Registrar		aryland	•	artment of H tificate of L		d Mental Hy	Reg. No.	006	2557	
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of D Month August		20 <b>06</b> °	3. Time of Death 5:45pm M	
	/Medic	al	Joseph Abrah  4a. Facility Name (If not institution, giv	<del></del>	<del></del>		4b. City, Town, or	L postion of F			unty of Death		
	Examin	er	Continuum Care				Sykesvi		Galli		Carroll		
	Funeral		5. Social Security Number 6. S		ge (In yrs. la	st birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of B				
	Director		217-09-5807	1 ₹ M 2 □ F	93	Yrs.	Months Days	Hours	June 2	irth Pay, Year) +, 1910	3	place (State or Foreign IMD	
	pu *		Usuel Residence of Decedent  10a. State 10b. County		10c Ciby	Town or Lo	cation					10d Inside City Limits	
	sho	ក		1.1	Too. Oily,	TOWITOLEO		11 -			10d. Inside City Limit		
	the M	Director	MD Carro	)11			Sykesvi	rite		10a Citizar	g. Citizen of What Country?		
	death with the Maryland ms 23a or 28a-f show trivust Le notified at		7624 Village Hou	ise Apartm	ents #	¥314		L784		Tog. Oilizei	USA	iridy r	
	death ms 20	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S				? (Specify Yes or Nuerto Rican, etc.)	0- 14.	Race - Ameri		
220	be filed within 72 hours after death with the Marylar ital Hygiene. Ind other than "natural", or Items 23a or 28a-f show event, Ite Medical Examiner must be notified.	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces  1 ☐ Yes 2 ☑  If Yes, Give  Year or Dates:			fYes, specify Cuba 1 □ Yes 2 ሺ No	n, Mexican, P Specify:	uerto Rican, etc.)		Black, White, ecify:	onc. White	
ָ ה	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	dent's Usual Occupa	ation	working	16b. Kind	of Business/In	ndustry	
V	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than * raumatic event, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done of DO NOT use retired	()	working				
7	led w lygier her th		12				Plumber				nbing		
2	ntal H ed ot	Be	17. Father's Name (First, Middle, Last Joseph Horan	)					Name <i>(First, Middle</i> Jnknown	e, Maiden Su	mame)		
Ž	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship	Time Print)		10h Mailin	Address (Street		r Rural Route Numb	har City or Tr	State 7in	o Code)	
<u>2</u>	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic		Mr. Vincent Horar				•		Sykesvill			o code/	
บ์	Hea Hea tem 3	1	20a. Method of Disposition	(5011)	20b. Pla		sition (Name of natory or other place		Date		ion - City or To	own, State	
2	bages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	Removal from State			Park Maus	1	8/17/06	Baltir	nore N	4D	
pallillo	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra ance.		21. Signature of Funeral Service Lice		HOII								
Ď	Dermi Depa Impo any ir		> Blian L	Hails	_	S	ykesville	e, MD 2	OME & CHA 21784 (410	795-	-1400	( 193)	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that cause one cause or each I	d the deeth. ine.	Do not enti	er the mode of dying	g, such as car	diac or respiratory a	arrest,		Approximate Interval Between	
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Bonset an disease or condition										
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
	<b>2</b> /4	_	Sequentially list conditions,	b. Due to (or as	- V	ence of:							
/	nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		A	- 7							
_	avecu al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):							
0000	icate be executed physician and s the burial-transit		(	_d	YSP	has	276						
Ö	:= D0 m	fedical		/		C	5				İ		
Š	th cer tendir r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnan	cy death 3⊡	Ectopic pregnancy			23d	Date of delive	•	
	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of dea	ath 5□	Other (specify)				Month	Day Year	
Ċ	hat th d by detach		Part II. Other significant conditions	contribution to death h	out not result	ting in the ur	adertuing cause give	on in Part I	23e Did	tobacco use	contribute to t	he cause of death?	
S S	signe d be o	1 by	Tarris official delications	John Balling to double	out not rosur	ung un uno un	idonying cadao give	ori iir i ditti.		les 2□N			
5	v requ	Completed							24a. Was				
ב ב	he tav e has	mp							auto		prior to co death?	ppsy findings available mpletion of cause of	
ō	an: T ifficate or, pa	CO	25. Was case referred primedical					26 Place of	1 ☐ Yes Beath (Check only	2 No	1 🗆 Yes	2 No	
>	ysicia is cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 E	R/Outpatien	t 3 DOA Othe	-	g Home 5 ☐ Res		Other (Specif	٠)	
5	ig Ph		27. Manner of Death	28a. Date of Inju	ıry 2	28b. Time of Injury	28c. Injury Work		28d. Describe			,,	
5	endin sath. or: Af	atio	1 Natural 5 Pending 2 Accident investigatio	n	, , , ,			Yes 2 □No					
<u>"</u>	or Atterder de irecto	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location ( City or To	(Street and N wn, State)	umber or Aura	al Route Number,	
2	oital c urs af oral D												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best miner: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred at the time restigation, in my op-	ie, date and pl pinion, death o	ace, and due to the ccurred at the time,	cause(s) and date and pla	d manner as s ce, and due to	tated. o the cause(s)	
	o the	Medi	29b, Signature and tyle of certifier		4.00.	-	29c. License	number	_	29d. Date si	gned (Month,	Day, Year)	
	F 5 F 0		JAY VC	Non	M	D	D-1	005	+218	08-	15-0	6	
	6		30 Name and address of person who	completed cause of o		23а) (Туре,	Print)	1	+218 , Westn				
	0		DR. Raman	3 Kaner	-1		lalculm a	dure	, Westn	unsta	MD	211517	
	Sta		31. Date filed (Month, Day, Year)		rar's Signatu	ire	1						
	Registr	ar	AUG 1 5 2	006 Med	de s	J. 19	ares.			·			

			1 - For Stata Registrar	State of M	laryland		artmen rtificate					giene Rag. No.	005	255	576
-64-7	Physici	an '	Decedent's Name (First, Middle, I								2. Date of Dea Month	ath Day	Year	3. Time o	
- In	/Medic	al	Naul Henke				41 01	T	h	( D 1)	August	10	2006	1:30	PM
40	Examin	er	4a. Fecility Name (If not institution, g		7)			Uncor	Location o	of Death			Bal 4	70 - 1	
	Funeral				ge (In yrs. last	birthday)		1 Year	If Under		8. Date of Birt		9. Birthp	lace (State	or Foreign
4.1	Director	3	218-26-7611	1₹M 2□F	75	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day DEC 31	, Year) , 193	Cour	MD	3
	Pu ,		Usuat Residence of Decedent		10.00										
	shov shov	۱ ا	10a. State 10b. County		10c. City, T								1	0d. Inside C	21∕∑ No
	Sea-f	ecto	MD Baltime	ore	Cock	eysv	111e	Codo				10a Citize	en of What Cour		-A
	with with	ä	10535 York Ro	ad				030				USA		id y r	
	72 hours after death with the Maryland Insturel', or Itema 23a or 28a-f show Vical Examinar must be multified at	Funeral Director	11. Marital Status	12. Was Deceden	f Ever in U.S.	13. \			spanic Ori	igin? (Spe	ecify Yes or No- Rican, etc.)		1. Race - Americ		
9	or ite	F	1 Never Married 2 Married				_			n, Puerto	Rican, etc.)		Black, White,	etc.	
8	ral',	d by	3 ☐ Widowed 4 ♣ Divorced	If Yes, Give Year or Dates			1 Yes	XIVO	Specify:				Specify: Wh:	ite	
21215-0036	"natu	Completed	15. Decedent's (Specify only highest of		1	(Give	dent's Usua kind of wor	rk done d	luring mos	t of work	ng	16b. Kind	d of Business/In	dustry	
12	within ane. then	mp	Elementary/Secondary (0-12)	Coltege (1-4o)	5+)		oo not us ount a		,			Тотг	n t o		
d 2	filed Hygid ther		17. Father's Name (First, Middle, La			21000	Juille	211 C	18. Mothe	er's Name	e (First, Middle,	Toyo Maiden S			
an	id be lental ked c	To Be	Henry Gustav	Henkelma	n				Anr	na W	enslaw	ski			
Maryland	shou and M a mar umat	-	19a. Informant's Name/Relationship		_	19b. Mailir	ng Address	(Street a					Town, State, Zip	Code)	
ĭ,	and 2 valith a 27 is ar tra		Paul M. Henke	1man/son		143	Bran	ndon	Roa	ad B	altimo	re,	MD 212	212	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or othar traumatic avent, the Madical Exemitive must be multilad at ance.		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3	□Removal from Stat		e of Dispo etery, crer	isition (Nan natory or o	ne of ther place	9)	(	Date	20c. Loc	ation - City or To	wn, Sfate	
Ë	Pag ment tant:		4 Donation 5 Other (Spe	cify)	Metr	o Cı	cemat	tory	, İr	ıc.	8/11/0	6 Ba	11timor	ce. M	D
3all	Depart Import any in		21. Signature of Funeral Service Lic	C. To	dd Dri	n ; 27	Crema Crema	Addres	s of Facility	Scie	ty of	Mary	yland,	Inc.	
	40244	299 Frederick Rd Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.													
			shock, or heart failure. List of			DO NOT BITE	er the mon	e or ayırıç	g, such as	cardiac	or respiratory as	1951,		Approximation of the Approxima	ween
541	Physician /Medical		disease or condition resulting in death)		nha"									years	
	Examiner			Parki	s a consequen	ice or):								Jan.	
**	4.5	ē	Sequentially list conditions, any, reading to ministrate cause. Enter Underlying Cause (Disease or injury	U	s a consequer	ite offr								year s	
/	cuted ad ransit	Examiner	that initiated events	c											
Ö,	e exe	EX	resulting in death) Last	Due to (or a	s a consequen	ice of):									
8760,	death certificate be executed e attending physician and d for use as the buriat-transit	Physician/Medical		d	-							-		euit	
9	eath certific attending p for use as f	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnance	,									
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal de at time of deat	ath 3	Ectopic pr					23	ld. Date of delive Month	_	Year
P.O.	the d	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown			2 Othor (3p	00,							
	The law requires that the de ate has been signed by the a bage 2 should be detached f		Part II. Other significant conditions	s contributing to death	buf not resulting	ng in the u	nderlying c	ause give	n in Part I		23e. Did to	bacco us	e contribute to ti	ne cause of	death?
rg	w require been sig should b	ed	Chimic renal	incoffice	rcy						1 🗆 Y	'es 2 🗆	No 3 ☐ Prob	ably 4 🗗	Jiknown
000	e law requ has been je 2 should	Completed by			/						24a. Was		24b. Were auto	psy findings mpletion of a	available
Ě		E O									perfo	rmed?	death?	2 No	4436 01
/ita	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?							of Death	n (Check only o	ne)			
<b>J</b> o	this al dir	ဥ	1 Yes 2 No	Hospital: 1 Inpa		/Outpatier			4 - 140				Other (Specif	y)	
no	Jing After fune	lo	27. Manner of Death  14 Natural 5 Pending  2 Accident investigat	28a. Date of In (Month, E	ay Year)	Bb. Time of Injury	M	8c. Injury Work	rai (? /es 2□		28d. Describe h	iow injury	occurred		
Division of Vital Records,	or Attending after death. Director: After in by the fune	flcat	3 Suicide 6 Could not	t be	niury - At home	a, farm, sfr			.03 2		28f. Location (5	Street and	Number or Rura	I Route Num	nber.
Θ	1 th 0	Certification:	4 - Homicide	building,	etc. (Specify)		, , , , , ,				City or Tox	n, State)			
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis and manner:	of examination	dge, death and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	nd place, ith occurr	and due to the ded at the time,	cause(s) a date and p	nd manner as s place, and due to	tated.	3)
	o the	Med	29b. Signature and title of certifier	and mainer:			290	. License	number		:	29d. Date	signed (Month,	Dey, Year)	
	- s - ŏ		Wand Kl	ly mo				D3.	1295	-		8	11/06		
•	í		30. Name and address of person wh	no completed cause of	death (Item 20	3a) (Type,	Print)						11/06 md		
	6		Wendy Klorsz	mo 67	11 N.C.	haoles	Ace	50	ite 4	1202	13~	A,	md	21207	1
0.0	Sta		31. Date filed (Month, Day, Year)	32. Regis	frar's Signatur	9									
1	Regist	ar	AUG 15	2006	K	1	and i	ī							

			For State Registrar	State of Maryland		rtment of H			iene 19. No 2006	25578
	£ &	e)	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic			HAINES				08	13 06	5;25 A M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or BALTI			4c. County of Death	1
	Francis		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign
*	Funeral Director			M 20 73	Yrs.	Months Days	Hours Min.	(Month, Day,		Virginia
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	Maryla a-f ehov	tor	MD 100. County	Too. Oity,	10411 01 20	Baltimo	ore			1X Yes 2 □ No
	with the 3a or 28	I Director	10e. Street and Number 6002 Glenoak Av	enue/		10f. Zip Code 2 1	1214	1	0g. Citizen of What Co USA	
336	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or items 23a or 28e-f ehow event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1		Vas Decedent of Hi f Yes, specify Cubar I □ Yes X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	within 72 hor ene. than "nature	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deceo (Give life. I	lent's Usual Occupa kind of work done d DO NOT use retired, OMEMAKE1	ation furing most of work )	king	16b. Kind of Business/I	
2	filed w Hygier Ither th		12  17. Father's Name (First, Middle, Last)	1				e (First, Middle, M	Maiden Surname)	
Maryland		To Be	Thomas Jord	lan			]	Bulah O	. Shaw	
	nd 2 alth a 27 ie		19a. Informant's Name/Relationship (Type William M. Whise		6008				; City or Town, State, Z imore, MD	
Baltimore,	Pages 1 and Healt of Healt of Healt of Healt or If Item 2 ry or other		20a. Method of Disposition 1 ☐ Mourial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	- 00	dens	sition (Name of natorior offer place etery	£h 8−18	Date 3 – 0 6	20c. Location - City or Rosedale,	Town, State Maryland
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service License	Etade	22	. Name and Addres	s of Facility EV	ANS CHA -Parkvi	APEL OF M lle,MD 21	EMORIES 234
H			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	CEREBRAL	FOF	HA				Onset and Death
100	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):			-		
	LXdiffile	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	METAS	TATIC	10 BR	AIN	
	led Insit	mlne	Cause (Disease or injury							
Ć	sicien and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	nte be nysicie he bu	Ca								
89 )	artifica ling ph e as tl	Med	IF FEMALE:							
P.O. Box	it the death certificate be executed by the attending physicien and lached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Ś	signed be de	þ	Part II. Other significant conditions con	tnbuting to death but not resu	lting in the u	nderlying cause give	en in Part I.		bacco use contribute to	
Record	e law requ has been je 2 shoul	Completed						24a. Was a autops perform	y prior to o	topsy findings available completion of cause of
a F	ician: The l certificete ha							1 ☐ Yes	2 DNo 1 □ Yes	2 No
Vital	Physician: r this certifice ral director, r	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 npatient 2 🗆 E	ER/Outpatier	nt 3 DOA Othe	oc	th (Check only on	ence 6 ⊡Other <i>(Spe</i>	n/w)
on of	ng ffe		27. Manner of Death 1 ☐Natūral 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	f 28c. Injun Worl			ow injury occurred	
Division	Dift o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, sti	reet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospitet within 24 hours a To the Funeral I completely filled	edical C		sician: To the best of my knowner: On the basis of examinat and manner stated.						
	within To the compl	Me	29b. Signature and title of certifier		,	29c. License	e number	2	9d. Date signed (Monti	h, Day, Year)
	4		HANIA KA	SEH.HN -	11	2 RE	5000	C	8/14/01	1
1			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)				
¥	)		HANTA KASSEH 31. Date filed (Month, Day, Year)	5601 LOC	17 B	AVEN B.	LVDBA	LTIMO	ORE, MD,	21239
2	Sta Regist	ate rar	AUG 15 2	mpleted cause of death (Item  56 0 00  32. Re strar's Signat	B. A.	pera				

			State of Maryland / Dep 1 - State Amend item#25,27,28a-f,perME,g858,8/15/	artment of Health and Medificate of Death	Mental Hygie Reg.	ne 006 25579
	Physicia		1. Decedent's Name (First, Middle, Last)  Farl Harold Harris		2. Date of Death Month July	Day 3. Time of Death 1:00am M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Death
			Continuum Care	Sykesville		Çarroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 377-12-24:10 10 10 10 10 10 10 10 10 10 10 10 10 1	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye June 27,	9. Birthplace (State or Foreign Country) MI
П	and w	}	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation		10d. Inside City Limits
	a-f sho	tor	MD Čarroll	Sykesville		1 ☐ Yes 2 No
	with the	Director	10e. Street and Number 6020 Fairfield Lane	10f. Zip Code 21784	10g.	Citizen of What Country? USA
	deeth	era		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than *natural', or Itams 23a or 28a-f show any injury or other traumatic event. The Medical Everting trains be inclined at ODGs.	by Funeral I	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced  Amped Forces? 1 Ayes 2 No If Yes, Give Year or Dates 1943-46	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:	o Rican, etc.)	Black, White, etc.  Specify: White
5	72 ho	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of won	king 16t	b. Kind of Business/Industry
121	within ene. than	ldmo	Elementary/Secondary (0-12)   College (1-4or 5+)	DO NOT use retired) Comptroller/Audito	r	Accounting
9	filed Hygi othar	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	
ylar	Menta Menta arked atic ev	To B	Walter Raymond Harris	Eleano	r Emily Ka	alis
Maryland 21215-0036	d 2 shi th and th sm 7 tsm traum			ling Address <i>(Street and Number or Ru</i> 5  Jim Pickett Rd.,		
	s 1 an of Heal itam 2 other		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)		c. Location - City or Town, State
Baltimore,	Page ment c ant: If		4 Donation 5 Other (Specify) Crestlaw	n Mem Gardens 7/1	7/06 Ma	arriottsville, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee  Buan C. Haut	Z Nama and Address of Facility HOM Sykesville, MD 217	E & CHAPEL 84 (410)-7	PA (Box195) 795-1400
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Batween Onset and Death
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			Onsar and Deam
	Examiner		Due to (or as a consequence of):	Pab	//	<b>Λ</b>
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Unisease or injury	8	7//	EDICAL EXAMINAE
<u>,</u>	icate be executed physician and the burial-transit	Examiner	resulting in death) Last  c.   Due to (or as a consequence of):	trylly 1	ATION APPROVED BY N	
8760,	ysicla	dicail	a HTV	L'ERTIFI	ATIO	
9	artifica ing ph e as th	Med	IF FEMALE:		507	
O. Box	law requires that the death certificate been signed by the attending Is should be detached for use as	Physician/Me	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P	signed to det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Vital Records,	s been si	Completed			24a. Was an	24b. Were autopsy findings available
- Re	The ate h page	lmo:			autopsy performed 1 ☐ Yes 2 2	
/ita	Physiclan: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?		th (Check only one)	
of	d is	- To	1 XYes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time		ome 5 Residence	e 6 Other (Specify)
ion	Attanding Pr r death. actor: After th by the funeral	atlon	1 ☐ Pending (Month, Day Year) Injury 2 ☑ Accident investigation May 27, 2006 Noon	Work? M 1 ☐ Yes 2 ☑ No		1 while walking
Division	l or Attandi after death. Diractor: A	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f Location (Stree	at and Number or Rural Route Number, State) Liberty & Linton Rds.
Ω	purs at caral D		side of road  29a. Certifier 1 Sertifying Physician: To the best of my knowledge, dea	ath occurred at the time, data and place	Sykesville,	MD
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
ł	with Com	Σ	29b. Signature and the of certifier  Clinera MD	29c. License number D - 00 54		7-14-06
	(0)		30. Name and ad it is of person who completed cause of death (Item 23a) (Typin	e, Print)	1/10 =+	7-14-06 minites MD 21157
	Sta	ite	31. Date filed (Month, Day, Year) AUG 1 5 2005  AUG 1 5 2005	1 weeging aliv	7	11119 3 2113
	Registi	ar	AUG 1 5 2006	34521		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** August 14, 2006 Kenneth Eugene Hile 6:06 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1900 Bennett Rd. Aberdeen Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | June 1, 19. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 **X**M 2 ☐ F 75 213 28 6351 Yrs. Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "naturel", or iteme 23a or 28a-f ehor tre Medical Examiner must be notified at 1 Yes 2 No Maryland Baltimore Essex Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 Middlesex Rd. 21221 USA death . Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 No If Yes, Give 1954/56 Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Service Technician Steel Company 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental P Pages 1 end 2 should be UNK. Isabel Hile permit. Pages 1 end 2 should be Depertment of Health and Menta Important: If Item 27 is marked eny injury or other treumatic events. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Lou Hile (Wife) 718 Middlesex Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition commetery, crematory or other place)
Holly Hill Mem. Gardens 8/17/2006 Baltimore, Maryland 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 21. Signature Funeral Servi Licensee Maryland 21221 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Winasy ONE Year **Physician** /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 1 Yes 2 No 26. Place of Death Check only one)
Other:
4 \( \text{Nursing Home} \) 5 \( \text{Resilience} \) Nother (pecify) Be 25. Was case referred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending within 24 hours efter death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2057061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMNAD. M- RANA 3 MD, 4920 - CAMPBELL BLVd, BALTIMORE MD, 212 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Aug 6, 2006 6:00 p Charlotte Hill /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Future Care—Charles Village If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2**V**□ E No. Carolina Director 239-12-5318 90 Feb 4, 1916 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand Mantal Hygelene.
Then to Health and Mantal Hygelene.
The state of the state of the steen "natural", or flema 23a or 28a-f ehow and it is a marked of the steen "natural", or other traumatic event, it is Madical Experiment and Les malliand. 1 Yes 2 No Baltimore Maryland N/A Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 2619 Cecil Avenue 21218 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) North Carolina Mutual College (1-4or 5+) Insurance Agent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Forbes Unknown ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 Melby Court Baltimore, Maryland 21234 Barbara Bell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If eny injury or 08/12/06 Lansdowne, Maryland Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Lices 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Pen turion **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner na ferum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal dea
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month signed by the eld be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 3 ☐ Probably 4 3 Onknown Completed 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: this certificete 1 ☐ Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 20 No 3 DOA 2 ER/Outpatient After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Than bon, m), em) D 57088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bastimon, mb 21202. ST Paul Plany Than Your 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Sparke Registrar 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2550 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HISEY Month Year **Physician** STACY 131 PM AUGUST 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 41 **Director** 220-88-5835 9,1964 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 X No Anne Arundel Pasadena Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8087 Forest Glen Drive death v 21122 U.S.A Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Self Employed other permit. Pages 1 end 2 should be life Department of Health and Mental Hy Important: if Item 27 is marked oth eny july or other treumatic event 9008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Garry Albert Masters Betty Louise Masters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty L. Masters/Mother 71 Martinque Circle Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 16, Aug 16 2006 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem.Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01479 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE 6 MONTHS /Medical Due to (or as a consequence of): Examiner FAILURE 4 YEARS RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed PULMONARY DISEASE 8 YEARS OBSTRUCTIVE CHRONIC attending physicien and Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown P.O. 9 Unknown pyı Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rmed? 20 No 1□ Yes 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) P After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OLCAY AKSOY, MEDICAL DOCTOR RES - 000 AUGUST, 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLCAY AKSOY, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 5 2006 Registrar

			For State Registrer	State of	Maryland		artment of H		d Mental Hyg	giene neg. No 0 0 E	25583	
			Decedent's Name (First, Middle,	Last)					2. Date of Dea	ith	3. Time of Death	
	Physicia /Medic		Rose L. Horv	at					August	12, 2006 Yea	3:00 P. M	
	Examin		4a. Facility Name (If not institution,	give street and num	iber)		4b. City, Town, or	Location of D	eath	4c. County of De	ath	
			Fairfield Nurs					wnsvil		Anne Ar		
	Funeral		5. Social Security Number 314-05-6494	5. Sex 1 ☐ M 2 <b>XCX</b> F	7. Age (In yrs. I	ast birthday) Yrs.	Months Days   Hours   Min.   (Month, Day, Year)   Country)					
	Director		Usual Residence of Decedent		88		April 12, 1918 Indiana					
	yland row		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits	
	a-f st	tor	Indiana La	ke	H	lighlar	nd				1 Xes 2 No	
	or 28	Directo	10e. Street and Number	_1_			10f. Zip Code	2	1	10g. Citizen of What	Country?	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, Ire Madical Examiraer must be notified at	rai	3042 Eder Stre				4632			USA		
	er de Items	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	Armed For		S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin in, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Hace - Ar Black, Wi	nerican Indian, nite, etc.	
36	urs aft	by	₩Widowed 4 Divorced	If Yes, Give	θ		1 ☐ Yes 2 🔯 No	Specity:		Specify:	White	
21215-0036	2 hou	Completed by	15. Decedent	Education		16a. Dece	dent's Usual Occup	ation	working	16b. Kind of Busines	ss/Industry	
215	e. en 'n	npie	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done of DO NOT use retired	duning most of	Working			
7	ed wi	Co	11			Неа	ad Cook			School Sy	stem	
and E	ed ta	Be	17. Father's Name (First, Middle, L Ivan Krapac	ast)					Name (First, Middle, Inces Goodma			
3	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then 'natural', or litems 23a or 28a-1 show armatic event, II a Madical Examilier must be nutilited at	ဥ	19a. Informant's Name/Relationsh	in (Type Print)		19h Mailir	ng Address (Street		r Rural Route Number		Zin Code)	
Maryland	カモアギ		Francine Wheel		ter		•				, MD 21108	
	s t and 2 should f Health and Men item 27 is marke other traumatic	1	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other place		Date	20c. Location - City	<u> </u>	
JO E	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		state	•	iwn Cemete	101	17/2006	Scherervi I	le, Indiana	
Baltimore,	그런 변경 .		21. Signature of Funeral Service L			22	2. Name and Addres	ss of Facility				
Ö	Depa Impo any i		Jum D	Houss	/	3	altimore 631 Falls	Henss- Road.	Seitz Fune Baltimore	eral Home, e. Marylan	Inc d 21211	
			23a. Part1. Fifter the disease, or of shock, or heart failure. List of	complications that canny one cause on ea	aused the death ach line.	n. Do not ent	er the mode of dyin	g, such as car	rdiac or respiratory arr	rest,	Approximate Interval Between	
S.	Pnysician		Immediate Cause (Final disease or condition	a Ashi	vation	Prin	111 PW/C				Onset and Death	
	/Medical Examiner		resulting in death)	Du to (	or as a consequ	uence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Lxammer	_	Sequentially list conditions, if any, leading to immediate	b. — Due to (	or as a consequ	ience of):					-	
	ted nsit	Examiner	Cause (Disease or injury	Due 10 (1	01 43 4 0011364	301100 01).					1	
Ć,	execun n and ial-tra	Exai	that initiated events resulting in death) Last	c. Due to (	or as a consequ	uence of):						
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	icai	1	d								
68	leath certifica attending ph ifor use as th	Aedi	IC CCMALC.									
Вох	th ce tendii	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregna irth 2 - Fetal		Ectopic pregnancy	,		23d. Date of o	lelivery Day Year	
о Ш	ne dea the at hed fo	Physician/Med	1 ☐ Yes 2 💢 No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of de own	eath 5	Other (specify)			WORT	Day Fedi	
0	ac o		Part II. Other significant condition	as contributing to de	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
Vital Records,	signed to det	d by	Remid entalling	inui l	wibhr	al Wa	Intar a	lines	1 🗆 Y	es 2 No 3	Probably 4 Dunknown	
COL	w requir been si should	lete			7		1 1111-111-11	A Partie	24a. Was a	an 24b. Were	autopsy findings available	
Be	he lav e has	Completed							- autops perfor	sy prior t med? death	o completion of cause of	
ta		a)	25. Was case referred to medical			<del></del>		26 Place of	1 ☐ Yes  Death (Check only or	2 <b>30</b> No 1 1 Y	es 200 No	
<u> </u>	Attending Physician: r death. ector: After this certifici by the funeral director.	To B	examiner? 1 Yes 2 No	Hospital: 1 🗆 li	npatient 2	ER/Outpatier	nt 3 DOA Oth		ng Home 5 Resid		pecify)	
0	ng Phys ter this neral di		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time o	f 28c, Injury			ow injury occurred		
io io	endir sath. or: Af he fui	atic	2 Accident investig	ation				Yes 2 □ No				
Division of	or Att	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 289. Place	of Injury - At ho ng, etc. (Specify		eet, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		20n Cortifier	Physician: To the	hact of my kee	wledge dest	h accurred at the ti-	no date and -	lace and due to the a	rausole) and manner	as stated	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical		xaminer: On the ba					lace, and due to the coccurred at the time, d			
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1,			29c. Licens	e number	2	29d. Date signed (Mo	nth, Day, Year)	
<b>!</b>	7.		· ()	11			73	8958		8/14/6		
١	0		30. Name and address of person v	no completed caus	e of death (Item	23a) (Type,	Print)		04 4	1 110		
	U.		Da freet Siny	Sellen	200 G	rain t	Hyhway	Sw 0	Plan Burn	nie MD2	1061	
	Sta		31. Date filed (Month, Day, (Year)	2006 32. B	gistrar's Signa	ture L	and a					
	Registi	ar	AUG 1 5	2000		~ 7						

## 06-06010

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

	otato of Marylana / Departine	ent of Health and Mental Hyate of Death	ygiene Reg. No. 201	16 9550					
Physician/ Medical Examiner	Decedent's Name (First, Middle, Last)  Cleo B. Heffner		2. Date of Death  Month Day Year  August 12, 2006	3. Time of Death 1937 hrs					
No	Facility Name (if not institution, give street and number)     Saint Joseph Medical Center	4b. City, Town, or Location of Death Towson	4c. County of Deat Baltimore Co						
Funeral Director	5. Social Security Number  6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	16 1030 Forei	gn					
Directo.	219-05-5626 1 M 2 F 85  Usual Residence of Decedent	Yrs	10, 10, 1920 Te	erinessee					
d 10 w any	10a State 10b. County 10c. City. Town Maryland Baltimore Owings	or Location 5 Mills		10d. Inside City Limits  1 Yes 2 No					
with the Maryland s 23a or 28a-f show a notified at once.	10e Street and Number 2817 Baublitz Road	10f. Zip Code 21117	10g. Citizen of What Cou USA						
or items 23a control of items 23a control of items 23a control of items	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		rican Indian, Black,					
s after death wi ral", or items riner must be by Funera	1 Never Married 2 XXMarried Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced or Dates:	1 Yes 2 No specify:	White Specify:	Э					
36 In 72 houn Inal "natu lical Exan	Flementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti ibrary Secretary		County					
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than 17 is marked other than 17 to Be Comple	17. Father's Name (First, Middle, Last)  Fred Backus	18 Mother's Name Vern	(First, Middle, Maiden Surname) ice Coggins						
MD 21 nd 2 should lith and Mer in 27 is man animatic eve	19a Informant's Name/Relationship (Type, Print)  Frank G. Dean Son-in-law  19b 19b	Mailing Address (Street and Number or F 36 Chargeur Road Rei	Rural Route Number, City or Town, State sterstown, Mary Lai	nd 21136					
more, Pages I and nent of Healt man: If item or other tran	1 XX Burial 2 Cremation 3 Removal from State cremato	f Disposition (Name of cemetery, bry or other place) 11 Church Cemerty 8/	Date   20c. Location - City or						
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traum	4 Monation 5 Other Specify: 21. Connection of Funeral Service Lies is e	22. Name and Address of Facility Burgee-Henss-Seitz 3631 Falls Road, E							
Physician	23a. Pan I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	1 3631 Falls ROad, E t enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and					
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a Atherosclerotic Cardiovascul Due to (or as a consequence of):	ar Disease		Death					
) Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
uted d ansit <b>Examiner</b>	Cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
60,  e be executed ysician and burial - transit	UNPENDED								
ox 6876 ath certificat attending ph or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Fetal death 3 Ectopic pregna Other (Specify)	23d. Date of deliver Month	y Day <b>Y</b> ear					
P.O. Besthat the degree of detached for by the best detached for by Physics	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to						
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the representation of Director. After this certificate has been signed by all Director. After this certificate has been signed by elemental director, page 2 should be detached in by the funeral director. To Be Completed by P			autopsy prior to performed? death?	utopsy findings available completion of cause of					
tal Reician: The certifical rector, pa	25. Was case referred to medical examiner?	26.Place of Death (Check of		es 2 No					
n of Vii ding Physic After this funeral dire	1 Yes 2 No Inospire 1 Inpatient 2 YER/Ou 27. Manner of Death 28a, Date of Injury 28b, 1	utpatient 3 DOA Other Nursin	g Home 5 Residence 6 Othe  28d. Describe how injury occurred	er:					
ion (ttending death tor: Aft the fun	1 Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No							
Division o Hospital or Attending 24 hours after death Funeral Director Aft Ref Hilled in by the funeral all Certification:		rm, street, factory, office building, etc.	28f. Location (Street and Number or Re or Town, State)	ural Route Number, City					
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certification or ompletely filled in by the funeral director.  Medical Certification: To Be C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated								
Ne ST S S	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d Date signed (Mc						
	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 F	Penn Street, Baltimore. MD 21201							
State Registrar	31. Date filed (Month, Day, Year)  ALIG 1 5 2006								

			1 - For State Registrar	State of Marylan		artment of H			ene g. No. 2 / 1 / 1	25585	
	Physici	an	Decedent's Name (First, Middle, Last)  The state of the state of					2. Date of Death	Day2006Yeer	3. Time of Death 12:32a M	
	/Medic Examin	cal	Leon R. Haines  4a. Facility Name (If not institution, give s Gilchrest Hosp	street and number)		4b. City, Town, o	or Location of Death	0 13	4c. County of Dea	ath	
	Funeral Director		5. Social Security Number 6. Security Number 214 – 38 – 3494	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/29		nthplace (State or Foreign ountry)	
	Maryland Ind III	tor	Usuel Residence of Decedent  10a. State 10b. County  MD Baltim		y, Town or Lo Vindso	r Mill				10d. Inside City Limits 1 ☐ Yes 2 ☒No	
	th with the 23a or 28a	al Direc	10e. Street and Number 8333 Mindale Ci	rcle # B		10f. Zip Code 2 1 2	244	10	g. Citizen of What Country? USA		
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health end Mental Hygiene. If item 27 ie marked other then "natural", or items 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of F f Yes, specify Cub I Pes 2 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	SDBCITV:		
Maryland 21215-0036	d within 72 ho piene. Ir then "natur Ir Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11th	cation e completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired	pation during most of worki d)	ng 1	6b. Kind of Business Taylor	s/Industry	
land	2 should be filed withir end Mental Hygiene. In marked other then raumatic event, I'm M	To Be C	17. Father's Name (First, Middle, Last) James Haines				18. Mother's Name Cecel	(First, Middle, Midale, Midale, Midale, Midale)	aiden Sumame) ers		
	and 2 should saith end Men n 27 ie marke ser traumatio		19a. Informant's Name/Relationship (Ty Marguitta Haines		19b. Mailin 8333	g Address <i>(Street</i> Mindale	and Number or Rura	B, Wind	City or Town, State, SOT MILI	zip Coop 21244	
Baltimore,	Par Int		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	amazalitaan Stata	etro C	sition (Name of natory or other plan Crematol	ey 8/14	/06 B	alto., N	MD .	
Balt	permit. Departrimports any inju		21. Signature of Fun Service License	//////-			erty Rd.			, MB <sup>1</sup> 2113 <sup>9°</sup>	
	Physician /Medical Examiner	9r	23a Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	UECK juence of):	er the mode of dyli	ng, such as cardiac o	rrespiratory arres	it,	Approximate Interval Between Onset and Death	
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rds, P.	w requires the been signed I should be det	Ď	Part II. Other significant conditions con	MELLIT	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did toba		o the cause of death?	
of Vital Records,		Completed	AMPUTATION,	BOTH LOW	er E	KTRETI	ES	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
ion of Vita	or Attending Physician; The I after death. Director: After this certificate ha in by the funeral director, page	ation; To Be	25. Was case referred to medicat examiner?  1  Yes  No	ospital: 1   Inpatient 2    28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur	4   Nursing nor	n (Check only one) me 5 ☐ Residen 28d. Describe how	ce Other (Spe	ocity to SACE	
Division	el or Atte s after de: al Directo ed in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	Street and Number or Rural Route Number, vn, State)		
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, death	occurred at the til restigation, in my o	me, date and place, a opinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)	
	Tor	Σ	29b. Signature and title of certifier	Freedle	Δ	29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)	
(	\( \)		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,		ules 8+/	Baoto	MD 2	1204	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 5 2005	32 Registrar's Signe	ature Los	ate .					

DHMH 17 Rev 1/2001

ORIGINAL

Joseph Albert Johnson

### Please Type or Print in Black Indelible Ink

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State of Maryland /	Department of Health and Mental Hygien

	F	I-For State Certificate of Deat		Reg. No. 2015 2558
Physician Medical Examine	1.	1. Decedent's Name (First, Middle, Last)  Joseph - A - Johnson, SR	2. Date of D Month August	Day Year 1007
	•	4a Facility Name (if not institution, give street and number) 4b City, 1300 Block Bank Street Baltin	Town, or Location of Death more	4c. County of Death
Funeral Director		NA 1M 2F 5/ Yrs. Mont	ler 1 Year If Under 24Hrs. 8. Date of his Days Hours Min.	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Aaryland 28a-f show any 1 at once.		Usual Residence of Decedent  10a. State  10b. County  NA  BALTIMORE		10d Inside City Limits 1 Tes 2 No
ith the Maryland 23a or 28a-f sho notified at once		318 . S. EDen . ST.	21231	10g. Citizen of What Country? $V \cdot S_r A$ .
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once and by Funeral Director		1 Never Married 2 Married Armed Forces? If Yes, special Yes 2 No 3 Widowed 4 Divorced If Yes Sieve Year or Dates 1 Yes 2	ent of Hispanic Origin? (Specify Yes or ify Cuban, Mexican, Puerto Rican, etc.)  No specify:	White, etc.  Specify: WhiTe
24 3 - 1	mpieted		Occupation (Give kind of work done rking life. DO NOT use retired)	16b. Kind of Business/Industry  LAVASSA CORP.
be fill brantal H	a [	17 Eather's Name (First, Middle, Last)  Kenald W Johnson	18 Mother's Name (First, Middl FDA . D. PR	ince.
MD 21 ad 2 should lith and Me n 27 is ma annuatic er	Ľ	JOSEPH Johnson, JR 310.5.7	DUACAN ST BAlto.	
More, Pages   an tent of Hea nut: If ite		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify  1. Sign ture of Funeral Service Licensee	natory 8/9/06	20c Location - City or Town, State BAHO. MD
1		Part I Enter the disease, or complications that caused the death. Do not enter the mode	Address of acility DELLA HOLD TELLA FUNERAL HOLD Northern RO. BALL	6 M 21734
Physician /Medical 		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease Countries are consequence of):		arrest, shock, or heart Approximate Interval Between Onset and Death
1	Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ecuted and - transit		cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resulting in death) Last County (Disease or injury that initiated events resul		
760, ficate be exect by physician and the burial - tr	edical	UNPENDED AMENDED		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfering Contributed by Dhysician Madical Endicated by Dhysician Madical Endicated by Dhysician Madical Endicated.	nysician/iv	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Special Control of the Special Control of the S		23d Date of delivery  Month Day Year
S, P.O. I juires that the signed by the detache	2	Part II. Other significant conditions contributing to death but not resulting in the underlying	1	d tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
tal Records, tian: The law require certificate has been signer, page 2 should be	Complet		1 ✓ Ye	as an topsy findings available prior to completion of cause of death?  1 Ves 2 No No No
Vital ysician:	a a	examiner? Hospital: 1 Innation 3 FR/Outneton 3	26 Place of Death (Check only one) ODA Other Nursing Home 5	Residence 6 ✓ Other Scene
Division of Vital Records, P. 1st after death.  The law requires the safer death.  The Unrector: After this certificate has been signed in by the funeral director, page 2 should be death.  The Recompleted by the funeral director, page 2 should be death.	-15	27. Manner of Death  Natural 5 Pending Pounds   Pending 2 Accident   Investigation   Pending 2 Accident   Pending 2 Pending 2 Accident   Pending 2 Pending 2 Pending 2 Pending 2 Pending 2 Pending 2 Pending 3 2006   Pending 2 Pending 3 2006   Pen	28c. Injury at Work? 28d Descrit	be how injury occurred xposed to hot environment
Division o Hospital or Attending Hours after death. Funeral Director: Afterly filled in by the fune.		3 Suicide 6 Could not be determined (Specify) Vacant Building	or Town	n (Street and Number or Rural Route Number, City n, State) ck Bank Street, Baltimore, MD
To the Howithin 24 F. To the Funcompletely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the cone 2 Medical Examiner: On the basis of examination and/or investigation, in mand manner stated		
	Me		C.C.M.E.	29d Date signed (Month, Day, Year) August 4, 2006
7		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Balti	more, MD 21201	
Stat Registra	~~	31. Date filed (Month, Day, Year)  AUG 1 5 2006		
DHMH 17 Rev 1/200	_	ORIGINAL		

		_	For State Registrar		State of	Mary	land /		artmen <i>tificat</i>			and Me	ental Hygi	ene g. No.2	06	255	87
	Physicia		1. Decedent's Name (First, Mide	fle, Last)		Joe	Jen	kins					2. Date of Death Month	Day	Year 2000	3. Time of De	
>	/Medic Examin		4a. Facility Name (If not institution		et and num		tal		4b. City,	Town, or	Location o		J	4c. Coun	ty of Death		
	Funeral Director		5. Social Security Number 249-38-4659 Usual Residence of Decedent	6. Sex 1 □ <b>X</b> Λ	1 2 F	7. Age (In	yrs. last 77	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Mar 7,	Year) 1929	Cour	lace (State or F try) Carolina	oreign
	the Maryland 28a-f ehow		10a. State 10b. Count  Maryland	N/A		100	c. City, To	own or Lo	cation	Ва	altimore				1	0d, Inside City I	
:	1th with the 23s or 28s	Funeral Director	10e. Street and Number 2306 Ruskin Avent	ıe					10f. Zip	Code	212	17	10	)g. Citizen o	f What Cour U.S.A	•	
920	or items	þ	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	rned	. Was Dece Armed For 1 XYes If Yes, Give Year or Da	ces? 2 🗌 No e	in U.S.		Was Dece f Yes, spe 1  Yes		ispanic Ori in, Mexican Specify:	gin? (Spec n, Puerto R	offy Yes or No- lican, etc.)		ace - Amend lack, White, city:		
21215-0036	should be liled within 72 hours of Mental Hygiene. marked other then "neture!", imatic event, the Madical Exa	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	est grade	tion completed) College (1	-4or 5+)	11	(Give	dent's Usu kind of wo DO NOT u	rk done d se retired	during most	t of working	g		Business/In Beneral S		
land 2	id be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle	, Last) Joe Jer	ıkins						18. Mothe	er's Name	(First, Middle, M Sara	faiden Sum ih Jenki			
S	nd 2 shou alth and M 27 ie mer r treumet		19a. Informant's Name/Relation Ruth Jenkins Wife	ship (Type	. Print)		1						Route Number, e, Maryland		m, State, Zip	Code)	
Baltimore,	85 = 9		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		noval from S	- 1	ceme	etery, crei	nsition (Nai matory or correct Ve	other plac		Da tery 0	ate 2 08/16/06		n - City or To wings M		
Balti	permit. Pa Depertmen Important eny Injury once.		1. Signature of Funeral Service Licensee  22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217														
}	Physician /Medical		23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	21/1			g, such as			est.		Approximate Interval Betwee Onset and De	ath				
	Examiner	-		ice of):													
8760,	certificate be executed ding physicien and ise as the burial-transit	Ical Examiner	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (	or as a co	onsequen	ice of):			_						
B.	death e atter d for u	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	c. If yes, out 1 Live b 4 Pregn 9 Unkno	irth 2 ⊡ ant at time	Fetal de	ath 3[	⊒Ectopic p ⊒ Other (s)		,			1	Date of delive	ery Day Ye	ar
rds, P.O	w requires that the been signed by th should be detache	۵	Part II. Other significant condi	tions conti	ibuting to de	eath but no	ot resultin	ng in the u	nderlying	cause giv	en in Part I			acco use co es 2 □ No		ne cause of dea pably 4 Zuni	
l Reco	The law ete hes b page 2 sl	Completed											24a. Was ar autops perform 1 Yes 2	ned?	b. Were auto prior to co death? 1  Yes	psy findings av mpletion of cau 2 No	ailable ise of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medi examiner?		spital:					Oth	05		(Check only on				
C E 1 Ø Natural 5 □ Pending (Month, Day Year) Injury Work?									ý) 								
Divis	al or Atte s efter des i Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	d not be mined	28e. Place buildii	of Injury ng, etc. (5	At home Specify)	e, farm, st	reet, factor	y, office		2	8f. Location (St. City or Town		mber or Run	al Route Numbe	97,
	To the Hospital or Attenwithin 24 hours efter deat To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certific (Check only 2 Medicone)	ing Physi al Examine	cian: To the er: On the ba and man	best of masis of example stated	ny knowle amination I.	idge, deal and/or in	h occurred ivestigation	at the tir	ne, date an pinion, dea	nd place, a ath occurre	nd due to the ca ed at the time, da	ause(s) and ate and plac	manner as se, and due t	tated. o the cause(s)	
	To the vithin 2 complet	M	29b. Signature and title of certification	lier $\mathcal{U}$ .	War	thin	L. N	1.D.	29	$B_{\mathcal{N}}$	o number	418	71	9d. Date sig Augu	ned (Month,	Day, Year)	0
	) •		29b. Signature and title of certifications  30. Name and address of personal control of the cont	t. W	atk'i	e of death	h (Item 23	3a) (Type	Print)	0,7	Men	netia	1 Hos	pital	, mi	>	
	Sta Registi		31. Date filed (Month, Day, Ye AUG 1	2 <b>0</b> 06	375	legistrar's	Signature	fo	arti								

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Maryland / Department of Health and Mental Hygiene

red Johnson		State of Maryland / Department of Health and Mental H		eg. No. 200	6 2558
Physicia	an/	Decedent's Name (First, Middle,Last)	2. Date of Deat	h	3. Time of Death
Medical Exami		Fred Johnson 4a Facility Name (if not institution, give street and number)  4b City, Town, or Location of Death	Month August 1,	2006 4c County of Dea	0845 hrs
		468 Walton Court Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr:  Months Days Hours Mir	<b>—</b> (	h(MM/DD/YYYY) 9. E	Sirthplace (State or eign South
Director	1	47-10-4251   1X   M   2   F   90   Yrs.	04/24	/1916	CountryCarolina
ans		Usual Residence of Decedent         10c. City, Town or Location           10a State         10b. County           10c. City, Town or Location			10d Inside City Limits
ž .	٦	Md N/A Baltimore			1 X Yes 2 No
Maryla 28a-f d at ou	Director	10e. Street and Number 10f. Zip Code	10	Og Citizen of What Co	untry?
vith the Maryland s 23a or 28a-f show e notified at once.		468 Walton Court 21201		J.S.A.	
5-0036 cd within 72 froms after death with the Maryland bygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? (S  If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	arican Indian, Black,
ifter de	by Fu	1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 X No 1 Yes 2 X No specify:		Specify B	ack
hours natur		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel		16b. Kind of Busines	
36 nin 72 chau "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Construction		Private	Company
5-00 ed with tygiene other	Son		e (First, Middle, N	Maiden Surname)	Company
21215-0036 old be filed within 7 Mental Hygiene. marked other thau c event, the Medica	a			nnson	
MD 2.  Id 2 Should  If h and M  In 27 is ma	2	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Sandra A. Harmon (daughter) 458 Tubman Ct., Ba			te, Zip Code) 21201
e, M and 2 Health irem 2		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	
nt: If		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify.  Mt. Zion Cemetery 8/7	/2006	Lansdowr	ne Md
Baltimore, MD 21215-0036 permit Teges i and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner</u>		21. Signature of Funeral Service Circuses 22. Name and Address of Facility			ic, ma.
		23a. Part I Enter the disease, or complications that the death. Do not enter the mode of dying, such as cardiac of the death.	e. Ball	timore. N	Approximate Interval
Physician /Medical		failure. List only one cause on each line.			Between Onset and Death
Fxaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiovascular Disease compile or condition resulting in death)  Due to (or as a consequence of):	cated by Tiyp	ermenna	
	<u></u>	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of).			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
rted J ansit	Exa	events resulting in death) Last  Due to (or as a consequence of).			
760, icate be executed the bysician and the burial - transit	Medical	UNPENDED AMENDED			
68760, certificate be inding physicise as the buri		IF FEMALE: 23c. If yes, outcome of pregnancy  1 Trive birth 23c. If yes, outcome of pregnancy  1 Trive birth 23c. If yes, outcome of pregnancy  1 Trive birth 23c. If yes, outcome of pregnancy		23d. Date of delive	•
Box 687; death certific	cian	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	ancy	Month	Day Year
Box 687  The attending properties as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			
_ = 50	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	bacco use contribute	to the cause of death?  obably 4 Unknown
ords, P.O. w requires that as been signed b should he deta	eted		24a. Was a		autopsy findings available
c law re has b	Completed			med? death?	
Division of Vital Records, tal or Attending Physician: The law requirs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should libe.		25. Was case referred to medical 26. Place of Death (Check		2 No 1	Yes 2 No
Vita lysicia this ce	o Be	examiner?		Residence 6 🗸 Oth	er: Scene
ling Pla After t funeral	T:T	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 Natural 5 Page 192 FOWND: 1 You 2 A No.		now injury occurred osed to hot envir	onment
ivision lor Attend after death. Director: d in by the t	catio	Pending Pending Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.	Certification:	Suicide  4 Homicide  6 Could not be determined (Specify) Multi-Family Apt.	or Town, S		
D To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and		<del></del>	
To the I within 2 To the I complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date		
	Σ	29b Signature and title of certifier  29c. License number  O.C.M.E.		29d Date signed (A	
7		30. Name and address of person who completed cause of death (Item 23a)		August 1, 2006	
7		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	tate	31. Date filed (Mogth, Day, Year) AUG 1 5 2006  32. Redistrar's Signature	<del></del> .	<del></del>	
Regis	_				
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			1 - For State Registrar		State of M	arylar	-			ealth a Death			leg. No.	2006	25589
	Physici /Medic Examin	al er	1. Decedent's Name (Findal Same)  4a. Facility Name (If not	institution, give s	street and number,	)	ones			Location of	f Death	Month tuges +	Day	2006 ounty of Death	3. Time of Death 16:47 M
	Funeral Director		JOHNS HOPKIN 5. Social Security Numb 220-64-74 Usual Residence of Dec	er 6. Sex	7. Ac		last birthday) Yrs.		r 1 Year	If Under 2 Hours	4 Hrs. Min.	B. Date of Birth (Month, Day	, Year)	Cou	nplace (State or Foreign untry) TIMORE
	Maryland     A-f ehow		10a. State 10t	b. County N/A			ry, Town or Lo								10d. Inside City Limits Yes 2 □ No
	atter death with the Marylar or items 23a or 28a-f ehow caloner cant be notified at	ral Director	10e. Street and Number	ADWAY				21	Code 213		:-2/5		U.S.		
036	ours after de rei', or item Execulaer	by Funeral	11. Marital Status  1 Never Mamed  3 Widowed 4	2 Married	12. Was Decedent Armed Forces' 1 Yes 2 If If Yes, Give Year or Dates:	?	'	was Dece if Yes, spe	cify Cuba	spanic ong n, Mexican, Specify:	, Puerto R	ify Yes or No- ican, etc.)		. Race - Amer Black, White pecifyBLA	e, etc.
0-CLZL	be filed within 72 hours after death with the Maryland at Hygiene. A thy Special of the than "natural; or items 23a or 28a-f show event, the Maulcal Examiner quart be notified at	Completed		Decedent's Educate Inly highest grade (0-12)		5+)	16a. Deced (Give life. MECHA	kind of wo DO NOT u	ork done o	turing most	of workin			of Business/I	
2	should be filed and Mental Hygie marked other umatic event, it	9	17. Father's Name <i>(Firs</i> JAMES SAMU		IES SR.							(First, Middle, C, PA			
	is 1 and 2 should of Health and Mer Item 27 ie marke other treumatic	1.77	19a. Informant's Name/FRANCINE	JONES	pe, Print)	non 1	2042	Ν.	WASH	INGT	r or Aural ON S	ST BAL	TO.	MD. 2	1213
Baltimore,	permit. Pages 1 Department of h Important: if ite eny injury or ot once.		20a. Method of Disposit  1 □ Burial 2 □ ℃  4 □ Donation 5 □  21. Signature of Funera	remation 3 R				JNT	other plac CREM	ATOR	Y AU			BALT	
Ba	Deprison Dep		23a. Part1. Enter the d	isease, or compli	ications that cause	d the dea	Ç2	łty:	ŊВ.	PRES	<u> Н86</u> г			HOME.	Approximate
	Physician /Medical		shock, or heart fail Immediate Cause (Fina disease or condition resulting in death)		Sepsis	S	quence of):								Interval Between Onset and Death 2 weeks
	Examiner	lner	Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injur	ons, tata	Preun Due to (or as										4 weeks
1760,	cate be executed bhysicien and the burial-transit	Ical Examiner	that initiated events resulting in death) Last	- C	Due to (or as	s a consec	quence of):							c	1 years
.O. Box 68	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	aldeath 3□	Ectopic p					23	d. Date of delin	very Day Year
rds, P	ires th: signed d be de	by	Part II. Other significan	nt conditions con	ntributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to			the cause of death?
		Completed												prior to c death?	topsy findings available completion of cause of
	ding Phys	atlon: To Be	25. Was case referred the examiner?  1 ☐ Yes 2 No  27. Manner of Death  1 ☐ Natural 5  2 ☐ Accident		lospital: Inpat 28a. Date of Inj (Month, Da		ER/Outpatier 28b. Time o Injury		28c. Injun Worl	er: 4 □ Nur	rsing Hom	(Check only only only only only only only only	ence 6	☐Other (Spec	rify)
-	- 9	Certification:	4  Homicide	Could not be determined	28e. Place of Ir building, e	itc. (Speci	fy)					City or Tow	m, State)		ral Route Number,
	To the Hospital or Ai within 24 hours after of to the Funerel Direc completely filled in by	Medical	(Check only 2 one)	Medical Exami	sicien: To the bes ner: On the basis and manner s	of examina	owledge, deat ation and/or in	vestigation	n, in my o	oinion, deat	d place, and the occurre	d at the time, o	date and p	lace, and due	to the cause(s)
0	2 10 10	2	29b. Signature and title	theh	ei				RES		20			signed (Month	
'/ ≥	)		11 1010	itheli ev	4940	Each	m 23a) (Type,	Print)	no	Batt	uno	re, m	0 0	st 11, 21204	
	Sta Registi		31. Date filed (Month, D	JG 1 5 20	006 32. H	liais Sign	ature	berk							

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y Jarboe		State of Maryland / Department of I-For State Certificate of Registrar	of Death Reg. No. 2006 255	59
Physicia dical Exami	ner	1. Decedent's Name (First, Middle,Last)  Mary Katherine Jarboe	2. Date of Death Month Day Year August 8, 2006  3. Time of Death 1932 hrs	
		4a. Facility Name (if not institution, give street and number) 312 South Parrish Street	4b. City, Town, or Location of Death  Baltimore  4c. County of Death  n / a	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 X F 61 Y	If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Min March 28, 1945	nd
nd show any ice.	_	$ \begin{array}{c cccc} \text{Usual Residence of Decedent} \\ \hline \text{10a. State} & \text{10b. County} & \text{10c. City, Town or Loc.} \\ \hline \text{Md.} & \text{n/a} & \text{Baltin} \\ \hline \end{array} $		_
ith the Maryland  23a or 28a-f show any notified at once.	Director	10e Street and Number 312 South Parrish Street	10f. Zip Code 10g. Citizen of What Country? USA	
ter death w	by Funeral	1 X Never Married 2 Married Armed Forces? If 1 Yes 2 X No 3 Widowed 4 Divorced If Yes Give Year or Dates 1	Vas Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14 Race - American Indian, Black, White, etc.  White  Specify	
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours aft not of Health and Mental Hygiene  tt. If iten 27 is marked other than "natural" other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during T th Home	ent's Usual Dccupation (Give kind of work done most of working life. DO NOT use retired)  16b Kind of Business/Industry  Own Home	
21215-00 uld be filed wit Mental Hygien marked other c event, the Me	a	17. Father's Name (First, Middle, Last) Edward George Jarboe, Sr.  19a. Informant's Name/Relationship (Type, Print)	18.Mother's Name (First, Middle, Maiden Surname)  Mary Alice Duvall  Ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
, MD 2 and 2 shoul ealth and N em 27 is n	To	Dorothy L. Benson (sister) 1910	O Griffis Avenue Baltimore, Md 21230  position (Name of cemetery, Date 20c. Location - City or Town, State	_
		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify  Other Specification 1 Removal from State Bayview		PA
Balti Permit. Departs Import injury		23a. Part I. Enter the disease, or complication that caused the death. Do not enter	1201 Dundalk Ave. Baltimore, Md 21222 or the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Inte	2 erval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Car Due to (or as a consequence of):	rdiovascular Disease Between Onset a Death	and
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		_
ecuted and and transit	al Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.		
O, be ev siciar	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy	23d Date of delivery	
(ecords, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - transi	Physician/	past 12 months?	Fetal death 3 Ectopic pregnancy Month Day Year Other (Specify)	
P.O.	<u>ج</u>	Part II. Other significant conditions contributing to death but not resulting in the	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown	
Division of Vital Records, P.O. Box 6876 and or Attending Physician: The law requires that the death certificate all Director: After this certificate has been signed by the attending physicial in by the funeral director, page 2 should be detached for use as the t	Completed		24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No 24b. Were autopsy findings avail prior to completion of cause death?	e of
Vital I hysician: this certifi Il director,	o Be	25. Was case referred to medical examiner?  1 V Yes 2 No  Hospital 1 Inpatient 2 ER/Outpatie	26 Place of Death (Check only one)  ent 3 DOA Dther 1 Nursing Home 5 Residence 6 ✓ Other Scene	
tion of trending Physics 1 death.	ation: T	27. Manner of Death  1 V Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month. Day, Year)  28b. Time of Death Investigation	of Injury 28c Injury at Work? 28d Describe how injury occurred  1 Yes 2 No	
ie e i	Certification:	3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, st (Specify)	treet, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, or Town, State)	City
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investi- and manner stated	courred at the time, date and place, and due to the cause(s) and manner as started igation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29c License number 29d Date signed (Month, Day Year)	
Δ.	2	29b. Signature and title of certifier  Mussa, Brassell U.D.	29d Date signed (Month, Day, Year) O.C.M.E. August 9, 2006	
7			1 Penn Street, Baltimore, MD 21201	
S	tate	31. Date filed (Month, Day Year) 5 2006 32. Restruc's Signature	E40	

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrer	State of Maryland		rtment of He		lental Hygie Reg.	2 U U D	25591
5	A W	_	1. Decedent's Name (First, Middle, Last)	1/				Date of Death     Month	Day Year	3. Time of Death
	Physicia /Medic	al .	VIRGINIA	Kutt		4b. City, Town, or L	ocation of Death	AUGUS.	7, 2006 4c. County of Dea	
	Examin	er	Saint Joseph Me	edical Cente		40. Oily, 10411, of L	Towso	n		imore
. 32	Funeral Director		5. Social Security Number 6. Sex 1 9 - 18 - 4485	7. Age (In yrs. last	t birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You APRIL 1, 1	9. Bir	thplace (State or Foreign buntry)  M.D.
	72 hours after death with the Maryland natural; or iteme 23a or 28a-1 show deat Examinat must be rediffed at		Usual Residence of Decedent  10a. State  10b. County  BACTIO	20	Town or Loc	PARKUIL	4			10d. Inside City Limits
	the M.	Director	10e. Street and Number	MORE		10f. Zip Code	e	10g	. Citizen of What Co	ountry?
	h with	ie D	3341 Woodsid	e Ave		212	34		U.S.A	*
	r deat	Funerai	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cuban	panic Origin? (Spi , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
396	urs afte	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2□No If Yes, Give Year or Dates:	11	□Yes 2□No	Specify:		Specify: L	hite
2-0	72 hou natura	eted	15. Decedent's Educa (Specify only highest grade		(Give k	ent's Usual Occupat	ion uring most of work	ing 16	b. Kind of Business	/Industry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired) トルTZLペドミ			PORTRIAT	CORP.
nd 2	filed Hygi other	Be	17. Father's Name (First, Middle, Last)	-			18. Mother's Name	(First, Middle, Ma		
Maryland	2 should be and Mental is marked raumatic ev	2	Frederick Grad  19a. Informant's Name/Relationship (Type		19b. Mailing			KRIENE		Zip Code)
	is 1 and 2 s of Health an item 27 is other traus		Charles Kutt		334/	woodside	e Ave.	Batto Mo		77
ore,	0 0		20a. Method of Disposition 1-Burial 2 □ Cremation 3 □ Re	moval from State		ition (Name of atory or other place	8/1	Date 20	c. Location - City or	Town, State
altimore,	#문문증 .	1	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		iney L	Name and Address	of Facility	06 T	DA	W).
Ba	Depa impo any is		( Vaul M. ST	tella	14 75	NISTELL	A Funer	BAlto MC	21234	
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. cause on each line.	Do not ente	r the mode of dying	, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death  EV YEARS
	/Medical Examiner	ă.	resulting in death)	Due to (or as a consequent POLMYALGIA		MATICA				10 YEARS
	ש יי	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent						
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):					
8760,	ate be chysician	ledicai	€ d.							
9	ertifica ling ph	Med	IF FEMALE:	c. If yes, outcome of pregnance					201 0	
O. Box	The law requires that the death certificate ite has been signed by the attending phys bage 2 should be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
ecords, P.	quires that n signed by uld be deta	þ	Part II. Dther significent conditions cont	ributing to death but not resulti	ing in the un	derlying cause give	n in Part I.	23e. Did toba	~	to the cause of death?
Œ	The law requiriate has been sipage 2 should I	Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of s 211 No
Vital	Physician: T this certifical ral director, p	Be	25. Was case referred to medical examiner?	ospital:		Otho		h (Check only one)		
of	Phys rthis ral di	: To	1 Yes 2 No	28a. Date of Injury 2	R/Outpatient 28b. Time of	28c. Injury	at Nursing H	ome 5 Resident		ecify)
ion	Attending I r death. ector: After by the funer	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 □ Y	? 'es 2 □ No			
Division	i Di i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28a. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C		icien: To the best of my knowl er: On the basis of examination and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	M.D.		29c. License			d. Date signed (Mor	oth, Day, Year)
	12		30. Name and address of person who con							-
0	St	ate	JEFFREY SELL M. 31. Date filed (Month, Day, Year)	32 #egistrar's Signatu	ire _		SON, MA	RYLAND :	21204	
6	Regist		AUG 1 5 200	6 then b	1 Apr	ngi.				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Ma		artment of Health and Martificate of Death		iene <sub>eg. No.</sub> 201	06	25592
			1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month		Year	3. Time of Death
	Physici /Medic		Margaret		Kirk	08		06	11:21P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County o	f Death	
		ш	1460 Washington Avenue		Severn		Anne A	rund	el
	Funeral			(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 28	Year)	9. Birthpl Count	ace (State or Foreign
	Director		215-12-7951 1□M 2\(\mathbb{I}\)F	83 Yrs.		Feb. 28	3,1923		" MD
	2 .		Usual Residence of Decedent	10c. City, Town or Lo	action			10	d. Inside City Limits
	aryla shov	_	10a. State 10b. County	_	Cation				1 ☐ Yes 2 No
	8a-f	Sct	MD Anne Arundel	Severn	T =		0.000		
	deeth with the Maryland rns 23a or 28a-f ehow r.mvat.be notified at	Director	10e. Street and Number		10f. Zip Code		0g. Citizen of Wi	nat Count	ry?
	eth v	'a	1460 Washington Avenue		21144		J.S.A.	4.000	
	te de	Funerai	11. Marital Status 12. Was Decedent E Armed Forces?		Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race Black	- Amenca , White, e	
9	hours efter turel', or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	•	1 ☐ Yes 2X No Specify:		Specify:	Wh	ite
2-003p	hour		15. Decedent's Education	16a Decer	dent's Usual Occupation	1	16b. Kind of Bus	iness/Ind	uetry
ņ	within 72 ene. than "nal	Completed	(Specify only highest grade completed)	(Give	kind of work done during most of world DO NOT use retired)	king	TOD. INITIA OF DAS	iii o sariii o	ustry
7	than the	Ĕ	Elementary/Secondary (0-12) College (1-4or 5	+)	Maker		Own Ho	ome	
ם ס	be filed within 72 hours effer deeth with the Marylan ital Hygiene. ad other than "naturel", or items 23s or 28s-1 show other than "naturel", or items 23s or 28s-1 show it its Medical Examinat must be notified at	ပိ	17. Father's Name (First, Middle, Last)			e (First, Middle, I			
/land	d be ental	To B	Jiles Lewis Jr.		Maybell	e Fuller			
_	es 1 and 2 should be of Heelth and Menta litem 27 ie marked r other treumatic ev	Ĕ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Number or Ru			itate, Zip	Code)
Mar	ith ar		Mrs. Rebecca Clark / Frien	d 1455	Washington Avenu	e Severn	MArvlar	nd 21	144
ō.	1 and Heelth tem 27 other to		20a. Method of Disposition		sition (Name of natory or other place) Aug.		20c. Location - C		
ၟႄ	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)				C	1	1 a MD
daltimore,	artme ortan injury		21. Signature (7)						le, MD
n D	permit. Pages Department of Important: If it eny injury or o		1 VICVO		Second Avenue SW	ngleton			
			23a Part 1. Enter the disease, or complications that caused	the death. Do not ent				7 210	Approximate
		0	shock, or heart failure. List only one cause on each lin	е. С	50 % K				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	moma	, 10 mas	west			
	Examiner		Due to (or as a	a consequence of):	00.00	0-0	_		
		Ā	Sequentially list conditions, if any, leading to immediate Due to (or as a	a consequence of):	age race	easea		-	
9	nsit	Examiner	Cause (Diseese or injury						
	al-tra	xai	that initiated events c	consequence of):					
8/PU	cate be executed physicien and the burial-transit	dical	L <sub>a</sub>						
200	ficate g phy as the	(4)	v						
XOR	at the death certific I by the ettending perseconds	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome				23d. Date	of delive	ry
ň	leath ette	cia	in the past 12 months?  1 Vec. 3 MNo.  4 Pregnant at		Ectopic pregnancy Other (specify)		Mon	th	Day Year
o.	the cy the achex	ys	9 ☐ Unknown						
J.	5 8 5	by PI	Part II. Other significant conditions contributing to death but	it not resulting in the u	nderlying cause given in Part I.	23e. Did tol	bacco use contril	bute to th	e cause of death?
<u> </u>	n sign	D D	Herleysen	Steer	Hesenel	1 🗆 Ye	s 2 No :	3 🗌 Proba	ably 4 Unknown
Ö	w require been si should l	Completed	Tollow Of ONO	20110100	Peus Or Close O.	3 24a. Was a	n 24b. W	ere autor	osy findings available appletion of cause of
Ĕ	: The faw cete has b ; page 2 sl	Ĕ	1000 Company	1		autops	med? de	ath?	
Vital Records	iicien: T certificet rector, pa		25. Was case referred to medical	0	26 Place of Dog	1 ☐ Yes : th (Check only on		∃Yes	2 LI NO
	ysicien: is certific director,	To Be	examiner? 1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatien	Other	ome 5 Aeside	-	/Snacih	4
ō	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of Injur	y 28b. Time of		28d. Describe ho			/
0	fun fun	15	1 ☑Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	M 1 Yes 2 No				
DIVISION	Attence r death ector: by the	E C	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ry - At home, farm, str	eet, factory, office	28f. Location (St		r or Rura	Route Number,
É	at or a afte i Dire	Certification:	4 Homicide determined building, etc	. (Ѕреспу)		City or Town	n, State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death	h occurred at the time, date and place	and due to the c	ause(s) and man	ner as st	ated.
	n 24   n 24   ne Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my opinion, death occu	rred at the time, d	ate and place, a	nd due to	the cause(s)
	within To th	Ž	29b Signature and tuto of certifier	M. D	29c. License number	2	9d. Date signed	(Mpnth, I	Day, Year)
)			I Auk 10	6	DO 2583	3	28/14	120	06
	1		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print)				
	5		Dr Sabong 206 Crain Highway	CU Clar I	Overesia Masselland Of	1061			
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registra	r's Signature	surnie Maryland 2.				
	Regist	rar	AUG 1 5 2006	The ball					

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month August 9, 2006 **Physician** 9:22p M Kolker **Elizabeth** Trene /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Sinai Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 2, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Yrs. 214-10-8770 90 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r then "natural; or items 23a or 28e-f ehov the Modical Exercipant be notified at Yes 2 No Maryland Baltimore n/a Direct 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21209 2809 Cheswolde Road America death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Restaurateur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if Item 27 is marked oth eny injury or other traumatic event <u>one</u>. William Whayland Sophia Calloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 407 Tuland S.E., Albuquerque, NM 87106 Louis Kolker (Son) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Arlington Cemetery Chizuk Amuno 1X Burial 2 ☐ Cremation 3 ☐ Removal from State August 14, 2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilifLoring Byers Funeral Directors, Inc. Mcc 333) 8728 Liberty Rd., Randallstown, MD 21133-4784 23a. Pand Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician yocardia! /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed3 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Dale of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation s after decrei Ate 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours a To the Funerei C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)42561 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 ( rassroads 1)1. 7 400 Martin 12055en, 32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 5 2006 Coarde REPORT.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [5] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 10:00 A M John Alan Kaline 2006 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Anne Arundel 5516 Patrick Henry Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye **Funeral** Days Months Hours 1**™**M 2□F 56 1949 Dec. Director 217 52 4005 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2X No Anne Arundel Baltimore Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 end 2 should be filed within 72 hours after death with ment of Heelth and Mental Hygiene.
ant: If item 27 te marked other than "naturel; or Iteme 23a or: ury or other treumatic event, the Medical Examere must be a U.S. 5516 Patrick Henry Drive 21225 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) 12th College (1-4or 5+) Florist Flower Shop 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Marie Meyers William Kaline Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert W. Kaline / Brother 6439 Cedar Furnace Circle Glen Burnie, MD. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its eny injury or of once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Glen Haven Mem. Park 8/15/2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatur Fundral Service Lig lono 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Event Pnysician toute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rasetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arterioscierote Cormany Artery Diverse 1 ☐ Yes 2 ☐ No 3 Probably 4 Denknown foot sleer 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s 1□ Yes 2Ū-No 25. Was case referred to medical Be 26. Place of Death | Check only one | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Pis. After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19667 Hereal Humanis 08-12-2006 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7310 Ritchie Highway # 508 Glen Bring Hamland 21061 (Levaur HS) technol

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Pogistrar's Signature

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		•	For State Registrar	Otate of Mic	zi ytaria /		tificate of			Reg. No	4000	) (3	1593
	Physicia		1. Decedent's Name (First, Middle, La.	Y() A ) ( O	Kich	bi 1			2. Date of De	ath	Year	3. Time	of Death
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of D	eath W	4c.	. County of Dea	th	<del>414</del>
			Harbor Hospi	tal (er	Herz	hinth days)	If Under 1 Year	If Under 24	Hrs.   9 Date of Bir	*6	N/A	thologo /Stat	o or Foreign
	Funeral Director		5. Social Security Number 16. S 212 10 7729	i⊠M 2□F	e (In yrs. last b 93	Yrs.	Months Days		Ain. 8. Date of Bir (Month, Da Feb. 2	8, Year)	913 Ma	thplace (State ountry) .rvland	
	ס		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	oum or Lo	cation					10d. Inside	
	Maryle f ehov	ō	Maryland N/A			Ltimo							es 2 No
	r 28a-	Irect	10e. Street and Number				10f. Zip Code				tizen of What Co	ountry?	
	ath wit	raiD	4005 Second St					225	0.10		U.S.		
936	ges 1 and 2 should be filed within 72 hours after death with the Marylend it of Heelih and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Macked Exphrime must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 12 Yes 2 1 1 Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2🏿 No	dispanic Origini an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	)-	14. Race - Ame Black, Whit Specify: Wh	te, etc.	
21215-0036	72 ho	Completed	15. Decedent's E. (Specify only highest gra		16	(Give	dent's Usual Occup	during most of	working	16b. K	ind of Business	/Industry	
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	e filed Il Hygir other	Be Co	17. Father's Name (First, Middle, Last					18. Mother's	Name (First, Middle	, Maiden	Sumame)		
ylar	ould be Mental narked o	To E		H. Kirby					na Anarin				
Maryland	d 2 sho th and 7 is my traum		19a. Informant's Name/Relationship ( John Kirby /	Type, Print) SON			Second S		r Rural Route Numb Baltimor				5
	es 1 an of Heel f item 2 r other		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place	1	Date		ocation - City or		
Baltimore	Page ment o ent: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			d Ri	ige Cemet	ery 8/			timore,		
Balt	permit. Page Depertment o importent: If eny injury or once.		21. Signature of Funeral Service Licer	gname	each	4-4	001 Ritch	hie Hig	Gonce Fu hway Bal	timo			
			23a. Part1. Enter the disease, or shock, or heart failure. List only	one cause on each li	the death. Done.	o not ent	er the mode of dyir	ng, şuch as cai	rdiac or respiratory a	rrest,		Approxim Interval E Onset an	Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a consequence	ce of):	prilur	nanco	<b>\</b>			80	ays
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	pe #s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (br as	a consequence	ce of):		:1			. 0110	2/1	5
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09289	0 2 0	cat		. Chr	J/C_	M	rial f	ibrill	MON			June	4000
Box 6	certificet inding phy use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1⊟Live birth	of pregnancy		Tennia di di				23d. Date of de	livery	
P.O. B	Q 0 Q	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnant at 9⊟Unknown			Ectopic pregnancy Other (specify)	у			Month	Day	Year
	requires that the een signed by th hould be detache	by Pi	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the u	nderlying cause giv	ven in Part I.			use contribute t		
ord	w require been si should b	ted	conary f	x tery	asec	R	CSING	1480	-/ -			robably 4	
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tal	ician: Th certificate rector, pag	0	25. Was case referred to medicat					26. Place of	1 ☐ Yes  Death (Check only	2/2/No	, 1 ☐ Ye	s 2□ No	
į Vi		ToB	examiner? 1  Yes 2 No	Hospital: 1 Inpatie	ent 2 ERV	Outpatier	nt 3□ DOA Oth		ng Home 5□Res	idence	6 □Other (Spe	ecify)	
o uc	ding P	ion:	27. Manner of Death 1 ☑Natural 5 ☑ Pending 2 ☑ Accident investigation	28a. Date of Inju (Month, Da	ry Year) 28b	b. Time o Injury	Wor	ryat rk? ]Yes 2 ∐ No	28d. Describe	how inju	ry occurred		
Division of Vital Records,	Attence r death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	jury - At home,	, farm, str	eet, factory, office	, 100 2 2 100		Street a	nd Number or R	lural Route N	umber,
Ö	ital or irs afte ret Dir	Cert			ic. (Specify)								
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of examination	dge, deat and/or in	h occurred at the til vestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time.	cause(s date an	) and manner a d place, and du	s stated. e to the caus	e(s)
	within To the compli	₩	29b. Signature and title of certifier		-		29c. Licens	se number	1	29d. Da	ate signed (Mon	th, Day, Year	)
			DRFUON	Mers	, MD	)	10	BO		A	ugusl	8,20	06
	PXI		30. Name and address of person who	completed cause of o	death (Item 23	a) (Type,	Print) H	MICH	1705 Pta	1	ente	0	21235
	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signature		P-A	1 '41	WEIZ	2116	ex , se	LAMP	PYNY
	Regist	rar	Aug 1 5 2	006   K	- K	A	MARK B						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6, 2006 6:55 AM M Nettie Kau1 August Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care Nursing Center Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 363-14-9456 1 ☐ M 2 💢 F 92 Yrs 1914 Michigan Director Feb. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at XXYes 2 □ No Bethesda Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e or 5205 Crown St. 20816 United States deeth Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3X Widowed 4 □ Divorced "naturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Depertment of Health and Mental Hygient Important: if item 27 ie merked other that eny Injury or other treumatic event, Italy 2006. Retail / Clothing 12 Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Geroge Zwick Julia Rakowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald W. Kaul / Son 5205 Crown St., Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 8/8/06 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Clos 22. Name and Address of Facility Rapp Funeral and Cremation Services M00382 Fillet John aun 933 Gist Ave., Silver Spring, MD 20910 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Failure to thrive /Medical Due to (or as a consequence of): Congestive Heart Failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien end Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 Unknown 9 I Hoknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Breast Cancer, Dementia 1 Tes 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy 2□ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No ours efter death. neral Director: A filled in by the fu investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8-7-2006 D35579 30. Name and address of person too completed cause of death (Item 23a) (Type Print)
Susan J. Miller, MD 6844 Tulip Hill Terrace Bethesda, MD 20816 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Elem & Sports AUG 1 Registrar 2006

**ORIGINAL** 

Velly pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6		-	State of Mar State Amend #14 Per FH G858 8	yland / Depa /16/06	artment of Health and M tificate of Death	Mental Hygier	ZHHb	25597
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)     GINGER	K	ELLY	2. Date of Death AUGUST 1	2006 <sup>ear</sup>	3. Time of Death 2:45 P M
9	Examin	er	4a. Facility Name (If not institution, give street and number) LEVINDALE HEBREW HOME		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	N/A
*:	Funeral Director		216-24-6415 1□M 2\XF	In yrs. last birthday) 84 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth 05/19/19/	9. Birth	place (State or Foreign ntry) NY
	Maryland f ehow		Usual Residence of Decedent  10a. State	Oc. City, Town or Lo				10d. Inside City Limits 1   Yes 2   No
	or death with the Marylan teme 23e or 28a-f ehow at must be notified at	ā	10e. Street and Number 7404 PARK HEIGHTS AVENUE		10f. Zip Code 21208	10g.	Citizen of What Cou	ntry? USA
980	aft all	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ev Armed Forces?  1 Yes 2 No No If Yes, Sive Year or Dates:	1	Mas Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	can Indian, etc. Black <del>WHITE</del>
21215-0036	l within jiene. r then the Me	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0.12)  College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring	. Kind of Business/In	dustry
Maryland	should be filed of Mental Hygis marked other matic event, I	To Be C	(0111111)	VASHINGTON		e (First, Middle, Maid WN)		UNKNOWN)
	es 1 and 2 s of Health ar If item 27 Is or other trau		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crem	natory or other place)	IUE - BALT	MORE, MD.	21208 own, State
Baltimore,	permit. Pag Department Important: I eny Injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee    Carriage   22	SERVICE CORP. 08/1 R. Name and Address of Facility SOL REISTERSTOWN R	LEVINSON		INC.	
	Physician /Medical Examiner					or respiratory arrest, fairch in		Approximate Interval Between Onset and Death
8760,	ate be executed by sician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):				
P.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
	v requires tha been signed I should be det	by	Part II Other significant conditions contributing to death by	not resulting in the u	nderlying cause given in Part I.	23e. Did tobace 1 ☐ Yes	2 3 Pro	
al Records,		Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
on of Vital	Attending Physician: Ir death. ector: After this certific by the funeral director.	tlon: To Be	25. Was case referred to medical examiner?  1  Yes 2  Hospitaf: 1 Inpatien  27. Manner of Death 1  Activated 5 Pending (Month, Day) 2  Accident investigation		nt 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5  Residence 28d. Describe how i		fy)
Division	al or Attendi s after death il Director: A od in by the f	Certification:	2 □ Cuiside 6 □ Could not be	y - At home, farm, str (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one)  Medical Examiner: On the basis of e and manner state	examination and/or in	vestigation, in my opinion, death occur	rred at the time, date	and place, and due	to the cause(s)
	To vitt	Σ	29b. Signature and title of certifier	m	29c. License number D33943  Print)  Print)  Print)  Print)	29d.	Must /	1, 2606
6	0		30. Name and address of person who completed cause of de-	ath (Item 23a) (Type,	Evindale 24	34 WZ	Pelvedes	re
4.	Sta Regista		31. Date filed (Month, Day, Year) AUG 1 5 2006	A April a Apri	ede .			

			1 - State Amend #17,18	State of Marylan 20a c&22 Per	d / Depa FH <b>986</b> Cer	ortme tifica	720/0 te of L	ealth and l 6 JH Death	Mental Hy	giene Reg. No.	2006	25598
			1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath		3. Time of Death
	Physici /Medic		Otis Lamar						Aug	o7	2006	1:40 AM
X	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. Cit	y, Town, or	Location of Deat	h	4c.	County of Death	1
			Soint Agnes 1	tospital			Bal	timore				
	Funeral		5. Social Security Number 6. Sex	IN OFF		If Und Month:	er 1 Year Days	If Under 24 Hrs Hours Min.		rth ay, Year)	9. Birth	place (State or Foreign ntry)
	Director		201-30-1000	M 2□F 81	Yrs.				Nov 26			
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ry, Town or Lo	cation						10d. Inside City Limits
	eho	ō	MD		altimor						}	1 Y Yes 2 □ No
	hours after death with the Maryland ture!; or tteme 23s or 28e-f show at Exertine must be nutitled at	Director	10e. Street and Number			104 7	ip Code			10a Citis	en of What Cou	ntor?
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	eath	Funeral	908 Nottingham Ro	au 12. Was Decedent Ever in U	S. 13 V	Was Dec		229 spanic Origin? (S	Specify Yes or No	)- I	USA 4. Race - Ameri	can Indian.
	Iter d	Fu	1 Never Married 2 Marned	Armed Forces? 1 □XYes 2 □ No	1	f Yes, sp	ecify Cubar	n, Mexican, Puer	to Rican, etc.)		Black, White,	
99	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW		1 🗌 Yes	2 <b>X</b> No	Specify:			Specify: bla	ack
ŏ	72 ho	Completed	15. Decedent's Edu	cation	16a. Deced	dent's Us	ual Occupa	ition	rking unk	16b. Kir	nd of Business/Ir	ndustry
2	within 7 ene. then 'n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	uring most of wo	nking allie			
7	e filed within al Hygiene. other then vent, ire Me	2	12	0						Glen	n L. Ma	rtin Co
P	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than 'naturel', or iteme 23a or 28e-f show event, its Medical Examinar mail be nutified at	Be (	17. Father's Name (First, Middle, Last)				unk	18. Mother's Na	me (First, Middle	, Maiden	Sumame)	unk
/a	should be and Mental marked o	2	Walter J. Laman	<b>C</b>				Lottie	Bebel_			
Maryland 21215-0036	s 1 and 2 should be 1 Heelth and Mental Item 27 le marked other traumatic ev		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Addre	ss (Street a	nd Number or Ri	ural Route Numb	er, City or	Town, State, Zij	Code)
	Heelth tem 27 other tr		Joyce Taylor/frier				-	Avenue :				
Baltimore,	of He		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □R		Place of Dispo cemetery, cren	sition (N natory o	ame of other place	9)	Date	20c. Lo	cation - City or T	own, State
Ĕ	Peg nent ant: i		4 □ Donation 5 10 Other (Specify)		rrison	For	est <b>V</b>	A 10/	18/06	O	rings Mi	11s,MD.
at	permit. Peges 'Depertment of Important: if ite eny injury or of once.		21. Signature of Euneral Service Librase	Nade / Virgero	22	. Name	and Addres	s of FacilitMar	ch Fune	ral F	lone	Ttwoot
<b>a</b>	8253		/ unil	11 Del			nore,	$MD = \frac{212}{212}$	01 21212	110	timore S 1 E. No	rth Ave.
	Physician		23a. Part1 Enter the disease, or/complied shock, or heart failure. List only or immediate Cause (Final disease or condition	cations that caused the deat ne cause on each line.	1	er the m	,	g, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec		<u>u ( )</u>	10.1					
	ed sit	niner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse.)	juence of j:							
o,	The law requires that the death certificate be executed the been signed by the attending physicien and tage 2 should be detached for use as the burial transit	Examin	that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
8760,	hysicine bu	dicai		1.		_						
9	ng pl	0	IF FEMALE:			-						
Вох	eath certific attending p for use as t	Physician/M	23b. Was decedent pregnant 2	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta		Ectopic	pregnancy			2	3d. Date of deliv	
	b deathed for	Sici	in the past 12 months?	4 Pregnant at time of of 9 Unknown	death 5	Other (	specify)				Month	Day Year
P.0	thet the de detached	Phy	9 Unknown									
Vital Records,	quires the	þ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying	cause give	en in Part I.	- 1	tobacco u: Yes 2[		he cause of death? bably 4 🖭 Inknown
00	w requ	Completed							24a. Was	an	24b. Were auto	opsy findings available
Re	The la	E								ormed?	death?	empletion of cause of
ta		O	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath Check only		1 🗆 Yes	2LTN0
5	Physician: this certific	0 0	examiner?	lospital:	] ER/Outpatier	nt 3□ [	Othe	· F:	dome 5 Res		Other (Speci	6.0
on of	ding Phy h. After thii funeral c		27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	-	28c. Injury Work	at ?	28d. Describe			97
Si	ttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	One Blace of Initial At h		M		Yes 2 □ No	204	/C11	/ Marian	
Division	s after d	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, tarm, str fy)	eet, facti	ory, office			wn, State)		al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medical		sician: To the best of my knoner: On the basis of examinating and manner stated.								
	within To the comple	Me	29b. Signature and title of certifier			2	9c. License	number		29d. Date	a signed (Month,	Day, Year)
	- > - 0		I. HAMDALLA	an wa			PI	7006	,	Au	9,07,	06
•			30 Name and address of person who or	ompleted cause of death (Itel	m 23a) (Tyne	Print\	, ,	,		(		
			29b. Signature and title of certifier  T. HANDAU A  30. Name and address of person who co  TSAM HAMDALIM  31. Date filed (Month, Day, Year)  AUG 1 5 2006	, Saint Agn	es Hos	Pit	J 19	100 Cake	on Aven	ueg	Baltin	nsre
3	Sta Registi	- 1	AUG 1 5 2006	See Hegistrar's Sign	ature	2						

11/26/1921

LAMAR

			For State Registrar	State o	f Marylan				lealth a D <i>eath</i>	and M	lental H	ygier Reg. 1	71111	6 2	5599
			1. Decedent's Name (First, Middle	, Last)							2. Date of E		Day Yes		ne of Death
	Physici /Medio		Ruth D. Leukhar	rdt							Aug.	11,	06		03 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution	-	n <i>ber)</i>		1		Location o				4c. County of D	eath	
			Holy Cross Hos			1 . 4 5 . 4 . 4		Silve or 1 Year	r Spr		0.000 (0		Montgom		
П	Funeral Director		5. Social Security Number 577–34–9164	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. $81$	iast birthday) Yrs.	Months		Hours	Min.	8. Date of B (Month, 2 Jan. 2	ay, Yea	1925 Wa	Birthplace (St Country) Shingt	ate or Foreign
			Usual Residence of Decedent		OI			L			Jan. 2	.0,	1927   Wa	SITTIISC	OII DC
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insid	de City Limits
	a-fall	ctor	MD Montgo	omery	Sil.	ver Sp	ring							10	Yes 2y∑No
	ि 28 इ. इ.	Director	10e. Street and Number				10f. Z	p Code				10g. (	Citizen of What	Country?	
	ath w		2305 Falling Co					904				<u></u>	USA		
	er de	Funeral	11. Marital Status	Armed Fo	dent Ever in U	.S. 13.	Was Dec II Yes, sp	edent of H ecify Cuba	ispanic Orig In, Mexican	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	10-		merican India /hite, etc.	ın,
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 💆 Divorced	ied 1 ☐ Yes If Yes, Giv Year or D	'e		1 🗌 Yes	2 🗷 No	Specify:	whi	te		Specify:	white	
Ş	be filed within 72 hours after deeth with the Maryland tal Hygiene.  All Hygiene.  All Cher then "natural; or itama 23a or 28a-f ahow ovent, "the Medical Exercities in that he motified at event," the Medical Exercities in that he motified at	per	15. Decedent	's Education		16a. Dece	dent's Us	al Occup	ation			16b.	Kind of Busine		
212	hin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give	kind of w DO NOT	ork done d use retired	during most f)	of worki	ng				
7	od with	E C	6	0011090 (1	40.01,	Tele	phone	ope	rator			H	otels		
פ	be filed tal Hygi d other event, t	Be (	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Midd	le, Maid	en Sumame)		
<u> </u>	should be nd Mental markad c	၉	Cecil D. Robbin								tzhugh				
	C4 G 20 90		19a. Informant's Name/Relationsh										y or Town, Stat		
e)	s 1 and of Health Itam 27 other to		John F. Burns -	- Cousin	20b. F	P.U.			Snep		SCOWN,	+	St VA 2 Location - City		te .
وّ	0 0		1 ☐ Burial 2 ☐ Cremation		State	cemetery, crei	matory or	other plac	1						
Baltımore,		- 1	4 Donation 5 Other (Sp 21. Signature 1 Funeral Service	1	Me	tro Cr	emato 2 Name a	OLY and Addres	A: A: A:  ug.	12, 20	906	Balti	more,	MD	
Ba	permit. Departimports eny Inj		KIM V	chila	nan		crema	tion rode	Soci	ety Pood	of Mar	yla	nd, Inc	1220	
	-		23a. Pag1. Enter the disease, or shock, or heart failure. List	complications that c	aused the deat	h. Do not ent	ter the mo	de of dyin	g, such as	cardiac o	or respiratory	arrest,	e, PID 2	Approx	rimate I Between
	Physician		Immediate Cause (Final disease or condition		onary A									Onset	and Death
	/Medical		resulting in death)	- 4.	or as a consec									Day	5
п	Examiner		Sequentially list conditions,	<sub>b</sub> Myoca	ardial	Infarc	tion							Day	S
7	p =	Iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consec	uence of):									
	ecute and trans	Examiner	that initiated events resulting in death) Last		nar Ar		iseas	se				_		Yea	rs
8760,	ate be executed hysicien and the burial-transtt	al E	<b>,</b> ,	Due to	or as a conseq	juence on,									
289	icate phys s the	dical		d.										-	
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregna								23d. Date of	delivery	
ň	death le atten ed for u	clai	in the past 12 months?	4□Pregn	irth 2 ∏ Feta ant at time of c		Ectopic   Other (	pecify)					Month	Day	Year
o.	by the de	hys	9 Unknown	9□ Unkno	own										
o, D	The law requires that the ste has been signed by the page 2 should be deteched.	by P	Part II. Other significant condition		eath but not res	ulting in the u	nderlying	cause giv	en in Part I.		23e. Dio	tobacc	o use contribut	e to the cause	of death?
ğ	w require been si should b	bed	Diabetes Mel.	Litus							1	] Yes	2 □ No 3 □	Probably	4 Punknown
Vital Records,	lawr as be	ple	Hypertention			***					24a. Wa	s an	24b. Were	autopsy find to completion	ings available
		Completed									per 1 ☐ Yes	formed'	death	1?	
Vita	alclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					Ī ou		of Death	Check on	one)			
	Phyel this o	၉	1 Yes 2 No			ER/Outpaties			4 L Nu				6 □Other (S	Specify)	
Division of	ding h. After funer	5	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig	9	th, Day Year)	28b. Time o Injury	' м	28c. Injun Work	yat k? Yes 2.∐1		28d. Describ	e now in	ijury occurred		
is.	deat ctor: y the	flca	3 ☐ Suicide 6 ☐ Could o	not be 280 Blace	of Injury - At h	ome, larm, st					28I. Location	(Street	and Number of	Rural Route	Number
<u> </u>	effer effer Dire	Certification;	4 Homicide determ	buildi	ng, etc. (Speci	(y)	oot, rasis	.,,			City or T	own, St	ate)		740,11007
	To the Hospital within 24 hours e To the Funeral I completely filled	alC	29a. Certifier 1 Certifyin	g Physician: To the	best of my kno	owledge, deat	h occurre	d at the tin	ne, date and	d place,	and due to th	e cause	(s) and manne	r as stated.	
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medical one)	Examiner: On the b	asis of examina ner stated.	ation and/or in	vestigatio	n, in my o	pinion, deat	th occurr	ed at the time	e, date a	and place, and	due to the cau	ısə(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	•			2	c. Licens	e number			29d. l	Date signed (M	onth, Day, Ye	ar)
	/		> Jump	an				D-32:	332			Aus	g. 11, 2	2006	
	4		30. Name and address of person					•		_					
	1		980/ Gcorgia 31. Date filed (Month, Day, Year)		54ite				r 5	pri	ng. M	0	21903	2	
	Sta Regist		Allo 15		and a digital	ature	and!	,							

		For State	State of Maryland	/ Department of He Certificate of L		al Hygiene	2006	25600
		Registrar  1. Decedent's Name (First, Middle, La:	t)	- Cortinoato or E		te of Death	- 0 0 U	3. Time of Death
Physici	an	20,20,10 1	5 GEORGE	17770		onth Da	Year	JUNE BW
/Medic Examin		4a. Facility Name (If not institution, give	7.75	4b. City, Town, or	- 10	0 - 4 - 11	County of Death	01:10
LXaiiii	161	7559 A1177	HOLPICE	1:000	non	1	BALTIM	DA3
Funeral		Social Security Number     6. S		st birthday) If Under 1 Year   Months Days	If Under 24 Hrs. 8. Da Hours Min. (M	te of Birth onth, Day, Year	9. Birtho	lace (State or Foreign
Director		919 48 1422	MM 2□F 60	Yrs.	150	- 41 10	146 11A	CARLE
pue *		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Location			1	0d. Inside City Limits
Mary#	5	Carlon Bassa	Par Par	2115. VO				1 ☐ Yes 2 No
28a-	Director	10e. Street and Number	I DICK	10f. Zip Code		10g. C	itizen of What Cour	ntry?
death with the Maryland ime 23a or 28a-f ehow ir must be notified at	0	BROTA PORB	IDIS ROAD	2123	14		A. 2.01	
death	by Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Decedent of Hi	spanic Origin? (Specify Y n, Mexican, Puerto Rican,	es or No-	14. Race - Americ Black, White,	
o ette	E/	1 ☐ Never Married 25 Married	TYOYes 2 □ No	1 ☐ Yes 2 No	Specify:	0.0.7	Specify:	GIC.
OUGO hours after ture!; or its		3 Widowed 4 Divorced	Year or Dates 57112	Mel			Ma	TITE
72 n 72	Completed	15. Decedent's E (Specify only highest gra		16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired.	luring most of working	G 83	Kind of Business/In	dustry
21215-0036 ed within 72 hours ett gjene "neturel", or er then "neturel", or	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	FLIGHT OF	EN ER	P3	Cica Oz 6	TARREDAC
Hygin ent,	BeC	17. Father's Name (First, Middle, Last	01 3.10	1 200111	18. Mother's Name (First	, Middle, Maide	n Sumame)	111011 1301
Maryland of 2 should be file th and Mental Hy 77 is marked oth traumatic event	To B	1) ALTER BG	221 30-121	TER	RUSALIE	Kr	205	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours efter death with the Marylan of Health and Mental Hyglene. Item 27 is marked other then "neture!", or iteme 23s or 28s-1 ehow other traumatic event, ir a Mudical Exam are mounted as confiled at	_	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Address (Street a	and Number or Rural Rout	e Number, City	or Town, State, Zip	(Code) 21234
Baltimore, Mi permit. Pages 1 and 2 Depertment of Health a important: if item 27 is eny injury or other tra		SHARON M. LE	SIER	3807 AVORD	AL ROAD	TARK	A 1,216	BYLAND
Baltimore, bermit. Pages 1 ar Depertment of Hea mportant: if item nny injury or othe		20a. Method of Disposition	l car	ce of Disposition (Name of netery, crematory or other place	e) Date	20c. l	ocation - City or To	own, State
Pag ment ment		4 □ Donation 5 □ Other (Special		KLOOD LETTE	dock 18	17	3 KirillE 1	HRYLAND
Balt permit. Depertr importe eny inju		21. Signature of Fulneral Service Lice	1500	22. Name and Address	S of Eacility CEM	ELTOR	is is	9834
<b>□</b>		CLES ACE		880F H	ARFORD 1909	O HARA	J. 77 1 10	CALANO
		23a. Part1. Enter the disease, or corr shock, or heart failure. List only	blications that caused the death. one cause on each line.	Do not enter the mode of dying	g, such as cardiac or resp	iratory arrest,	`	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	OCULAR MELAN	OMA				
/Medical Examiner		ſ	Due to (or as a conseque	ence of):				
	6	Sequentially list conditions,	b. Dira to (or as a nonseque	anne of):				
uted d insit	Examiner	Sequentially list conditions, it are, leading to introduct cause. Enter Underlying Cause (Disease or injury						
60, be executed icien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
. Box 68760, death certificate be executed e attending physicien and d for use as the burial-trans	dical		. d.					
fiftica	Med	IF FEMALE:						
Box 68 leath certifice attending pt	hysician/Med	23b. Was decedent pregnant	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of			l.	23d. Date of deliver	ery Day Year
O. E.	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	ath 5 Other (specify)			MOITH	Day 16a1
that the led by the detache	<b>a</b>	Part II. Other significant conditions	contribution to death but not result	ting in the underlying cause give	on in Part I	3e Did tobacco	use contribute to t	he cause of death?
Ords, P.O requires that the een signed by th hould be detache	ğ	atti. Ottor significant conditions	onthoding to death but not result	ang in the underlying cause give	SIT SIT FOREIT.	1 ☐ Yes		
Cord	Completed					r		
Rec The law ite hes b	臣				²	4a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Vital Relician: The lector, page	ပို	25. Was case referred to medical				□Yes 2 <b>]</b> KΩN	o 1 ☐ Yes	2□ No
of Vita Physician: this certific ral director,	o Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3□ DOA Othe	er: 4 Nursing Home		6 ViOthor (Special	MOCDICE
D Of g Phys er this neral di	-	27. Manner of Death		28b. Time of 28c. Injury		escribe how inj		mospice
Vision Attending r death. ector: After by the fune	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation			K? Yes 2 □ No			
	100	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office		ocation (Street a	and Number or Run	al Route Number,
Diversity or ours after our after our filled in filled i	Certification:		I Silding, Old. (Oppolity)			, 5. 7 5, Ola	,	
To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier (Check only 2 ☐ Medical Exa	nysician: To the best of my knowniner: On the basis of examination	rledge, death occurred at the time	ne, date and place, and di	ue to the cause(	s) and manner as s	stated. o the cause(s)
To the H within 24 To the F complete	Medical	one)	and manner stated.					
vitit To To To To To To To To To To To To To	2	29b. Signature and title of certifier		29c. License	e number		ate signed (Month,	∪ay, rear)
1	Ì	147		199	3125		8/14/06	
12		30. Name and address of person who			HTMONTING :-	01000		
1	ate	DR. TARIQ MAHMO	22 Designate Signatu		TIMONIUM, MD	21093		
Regist		AUG 15	2006 Security	13. PROBLE				

2:05 p.m.

AUGUST 13, 2006

LAWRENCE LESTER

		1	For State Registrar	ate of Maryland		rtment of H			ene 3. No. 2006	25601
	Physicia		Decedent's Name (First, Middle, Last)  BESSIE		LIF	SSHUTZ		2. Date of Death Month AUGUST	10°, 2006°	3. Time of Death 2:56 P M
	/Medic Examin		a. Facility Name (If not institution, give street  11 SLADE AVENUE #80				Location of Death	1	4c. County of Death	IMORE
Ä	Funeral Director		Social Security Number 6. Sex 1 $\square$ M	7. Age (In yrs. la 2 7 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Bay. 1	9. Birth	nplace (State or Foreign untry) NC
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County  MD BALTIMORE		, Town or Lo	cation IMORE				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the I	۵	10e. Street and Number 11 SLADE AVENUE #80	11		10f. Zip Code	21208	10	g. Citizen of What Co	untry? USA
9	filed within 72 hours after death with the Maryland Hygiene. What then "netural", or Itema 23e or 28e-f show with the Medical Evanther must be notified at	F	11. Marital Status 12. V A 1 Never Married 2 Married 1	/as Decedent Ever in U.S rmed Forces? □Yes 2 MNo Yes. Give		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2X No		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	ncan Indian,
Maryland 21215-0036	nin 72 hours  in "netural", Medical Ero	Completed by	15. Decedent's Educatio (Specify only highest grade con	ear or Dates:  n npleted) college (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	6b. Kind of Business/	
d 212	filed with Hygiene other the	е Сош	17. Father's Name (First, Middle, Last)		SECRI			ne (First, Middle, M		
rylan	should be ind Mental marked c	To Be	JACOB  19a. Informant's Name/Relationship (Type, F	Print	KADI:		REBE		RA City or Town, State, 2	NBINOWITZ  Tip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Begrafinent of Health and Mental Hygiene Hipportant: If tiem 27 is marked other than "natural", or tlama 23a or 28a-f show important: If item 27 is marked other than "natural", or their interface or continual to a continual to		JANET RAFKY / DAUGHT  20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Remo	TER 20b. PI	11 SI lace of Dispo		UE #801	- BALTIMO	RE, MD 212	208 Town, State
Baltimore,	permit. Pa Departmer Important eny injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	attle	22	2. Name and Addre	ss of Facility	OL LEVINS	SON & BROS	., INC.
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	ons that caused the death use on each line.			,	c or respiratory arre	st,	Approximate Interval Between Onset and Death 2405
Oktr.	/Medical Examiner		resulting in death)	Amim P	1	LLATTON	J			4 mos
	be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events caulting in death) Last	Antrive 5 c	uence of):					was
68760,	m > m	cai	(d	CHAONIC C	Asm	ecruc (	Pulmon	my Di-	sense	54ns
.O. Box (	The law requires that the death certificate bite has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Med	in the past 12 months?	lf yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of di 9 □ Unknown	I death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of de Month	livery Day Year
۵.	luires that the signed by all the detact	þ	Part II. Other significant conditions contrib	لدنانا				1 □ Ye		o the cause of death?
Vital Records,	The law require Ite has been si oage 2 should b	Completed	Hyrencipia miture vnv 25. Was case referred to medical	E PROLAPS	& Im	ma Ret	50 16,797	24a. Was ar autops perform	24b. Were a prior to death?	utopsy findings available completion of cause of
	ysician: The is certificate h director, page	Be	25. Was case referred to medical examiner?  1 Yes 2 No			0:	her		ence 6 □Other (Spe	ecify)
Division of	ing Ph J. After th funeral	Certification: To	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation	Rea. Date of Injury (Month, Day Year)	28b. Time ( Injury	of 28c. Inju Wd M 1	iry at ork? ] Yes 2 No	28d. Describe ho	ow injury occurred	
Divis	To the Hospital or Attend within 24 hours after death To the Funerel Director:	Certific	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	(y) 			City or Towr	n, State)	
	he Hospi n 24 hour he Funer pletely fill	Medicai	(Check only 2 Medical Examiner one)	an: To the best of my kno On the basis of examina and manner stated.	owledge, dea ation and/or i	nvestigation, in my	opinion, death occ	curred at the time, d	ate and place, and du	e to the cause(s)
	To T	Σ	29b. Signature and title of certifier	Zanto. F	7		Se number ) UUこ88		9d. Date signed (Mon	
	20		30. Name and address of person who come	eleted cause of death (Iter	m 23a) (Type	Print)				
1 100	Si Regis	tate trar	31. Date filed (Month, Day, Year) AUG 1 5 2006	2. Registrar's Sign						

State of Maryland / Department of Health and Mental Hygiene 25602 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician JOAN ELLEN MOELLMANN 1:50 AM AUGUST /Medical 4a. Facility Name (If not institution, give street and number)

ST AGNES HOSP 4c. County of Death 4b. City. Town, or Location of Death Examiner HOSPITAL BALTIMONE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Hours 217-40-1375 Director Maryland Sept 18, 1942 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Iteme 23e or 28a-1 ehov traumatic event, the Madical Examinar rount be notified at 1 ☐ Yes 2X No Director Baltimore Maryland Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2103 Chantilla Road 21228 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipiry or other traumatic event page. Be Lawson Daniels Lois Ahrens 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Richard A. Moellmann (Husband) 2103 Chantilla Rd., Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 8/16/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility 237 E. Patapsco Avenue, Balto. McCully-Polyniak Funeral Home, P.A. Md 21225 21225 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NETASTATIC -MAG CANCER **Physician** LINKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sacretally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE LUNG DISEASE Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No o the Hospitel or Attending Physicien: funeral director. Be 25. Was case referred to medical 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 | Pending within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Greck only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P18620 Mugle completed cause of death (Item 23a) (Type, Print) Or CATON AVE 32. Registrar's Signature BALTIMORE MARYLAND 21229 900 31. Date filed (Month. Day, Year) State Registrar 2006

MOELLMANN,

State of Maryland / Department of Health and Mental Hygiene 25603 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Willie Frances McCoy 14:10PM 0 8 11 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Specialy mare MIVERSITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 16, 1932 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Days Hours 1□M 20 F 365-36-2419 74 Yrs. Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Modical Examinar must be multiled at MD 1 Yes 2 No N/A Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1138 Washington Blvd 21230 U.S.A. filed within 72 hours after deeth Funeral permit. Pages 1 and 2 should be filed within 72 hours after dee Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Examinary once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify.White 1 ☐ Yes ⊉QXNo Specify: þ 3 ☐ Widowed 4 🗷 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Nurse's Aid Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Monroe Estep Bertha May Carter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tresa Morris/Niece 1138 Washington Blvd. Baltimore MD 21230 20b. Place of Disposition (Name of cametery, crematory or other place)

New Cathedral Cemetery 8-15-2006 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ urial 2 ☐ Cremation 3 □Remg New Baltimore, MD \* 4 □Donation 5 □ Othey (Specify) Signalure of Funeral Service Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry kd. Lansdowne MD 21227 P nt1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician monia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1.☑Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 Yes 2 × No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 54 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2, No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
(MARINEHTA, MD 601, South Charles St, Baltimere, MD 21230 7 (HARUMEHTA, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

			State of Maryland / Department of Health and  Certificate of Death	Mental Hyg	_	6 25604
n.			1. Decedent's Name (First, Middle, Last)	2. Date of Deal	, Day Ye	3. Time of Death
	nysicia Medic		Mary Nunez	Hugusi	3, 200	6 12 pm
E.	xamin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dec  MARMOND GENERAL LISDE TO RALHMORE	ath Lv	4c. County of D	eath
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi	IS. B Date of Birth		Birthplace (State or Foreign
1	neral ector		436-50-5684 1		Year) 1928	Country) unk
	50101		Usual Residence of Decedent	000 20,	1720	
faryland	4		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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를 유 공	Su ag	Dire	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	Country?
ath w	Sunt	rai	501 W. Franklin Street 21201			SA
er de	100	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 Nove	(Specify Yes of No- erto Rican, etc.)		rmerican Indian, Vhite, etc.
)36 Irs at	Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No Specify: Year or Dates:		Specify: 1	vhite
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W - W W -	tre un		19a. Informant's Name/Relationship (Type, Print)  Md General Hospital  19b. Mailing Address (Street and Number or I  827 Linden Avenue B			
e, M	other		20a Method of Disposition 20b. Place of Disposition (Name of	777	MD 2120 20c. Location - City	
Baltimore	: 🔄 📗		1 Burial 2 Cremation 3 Removal from State			
Baltimo Permit. Pag Department	eny injury c once.		4 Donation 5 Mother (Specify) in state  21. Signature A mineral Service icensee Conald Wade Virector State Anatomy Boar	-		
De de de de de de de de de de de de de de	eny l		and the state of t	rd 655 W.	Baltimor	e Street
			23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, of heart failure. List only one cause on each line.	ac or respiratory arr	est,	Approximate
Physi	ician		Immediate Cause (Final			Interval Between Onset and Death
	dical		disease or condition resulting in death)  a. Due to (br as a consequence of):			
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70	#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.			
ecute	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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- a	. 00		d			
OX (	for use as the	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery
Box death certification	d for	ciar	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
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S, P	be det	by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contribut	e to the cause of death?
of Vital Records, Physician: The law requires the	should t	ed		1 🗆 Ye	es 2 No 3	Probably 4 Dunknown
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of \	9 9	၉		Home 5 Reside		Specify)
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Division 1 or Attending effer death.	inb	Certification;	4 Homicide determined determined building, etc. (Specify)	City or Town	n, State)	nural noute lyumber,
spita	) fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plant	ce, and due to the ca	ause(s) and manne	r as stated.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours effect death.	pletal	Medical	(Check only one)  1 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occand manner stated.	curred at the time, d	ate and place, and	due to the cause(s)
Tot	CO	Σ	29b. Signature and title of certifier 29c. License number	/	9d. Date signed (M	onth, Day, Year)
			NZ MD 84544		8/3/6	16
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AST ZEMAR (OMR, M. ) + 70 Wary and 6	remorno	Maria	40
	Sta	10	31 Date (Worth, Day, Year) 82. Registrar's Signature	W/MW	1402/1	1ac
R	egistra		31. Date Died (Month, Day, Year) AUG 1 5 2006			

State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death	F	eg. No.	0 23003
			Decedent's Name (First, Middle, Last)		2. Date of Dee Month	th Day Yee	3. Time of Death
¥.	Physicia /Medic		George Nelson		08	12 0a	Le 645AM
	Examin		4e Fecility Neme (If not institution, give street end питьег)	4b. City, Town, or	Location of Deeth	4c. County of D	eeth
			Overleu Health & Rehab 6116 Bel	air Rd. Baltimos			
4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest b	Months Davs Hours Min		Year) 9.	Birthplace (Stete or Foreign Country)
	Director		233-32-7403	Yrs.	0//04/	1935 W.	. Virginia
3	2 3	- 1-	Usuel Residence of Decedent           10a. Stete         10b. County         10c. City, To	wn or Location			10d. Inside City Limits
	show	_					1 ☐ Yes 2€No
	28 4	Directo	MD BALTIMORE FOR	10f. Zip Code		log. Citizen of Whet	Country?
3	23a or 28a-f shows to be notified at	ត់					-
1	M 23	Funeral	12506 Harford Rd.  11. Marital Status 12. Wes Decedent Ever in U.S.	21051	Specify Yes or No-	USA 14. Race - A	umerican Indian,
_ :	the state of	5	Armed Forces?  1 Never Married **Married 1 Yes **XNo	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, W	/hite, etc.
<u> </u>	rai', or items	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	1 ☐ Yes 2X No Specify:		Specify:	white
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פַ י	of Hy	Be	17. Father's Neme (First, Middle, Last)	18. Mother's Na	me (First, Middle,	Maiden Sumame)	
/lan	Mente rked fice	0	John Nelson	Lau	ra Lambe	ert	
Mar	e me	- 9	, , , , , , ,	9b. Mailing Address (Street and Number or F	Rurel Route Numbe	r, City or Town, Stet	te, Zip Code)
	aith 27 i	1	_	2506 Harford Rd.			
Baitimore,	of F		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of tep, crematory or other place) Air_Memorial	Aucr.,	20c. Location - City	
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<u> </u>	porting in its	- 1	21. Signature of Juneral Service Licenses	22. Name and Address of Fecility Evans Funeral		wport Dr	
n	20229	13		Chapel- Fel Air	Fore	st Hill,	MD .21050
			23a. Ray1. Enter the disease, or complications that caused the deeth. Di shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
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ě	has b	Be Completed			2200	~	of death?
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Division of	or Attanong Prysician: eftar death. Director: After this certifici d in by tha funaral director,	Certification:	4 Homicide building, etc. (Specify)		City or Tow	m, State)	
	pours ours oral fille		29a. Certifier 1 Certifying Physician: To the best of my knowled	ge, death occurred et the time, date end place	e, and due to the	cause(s) and manne	or as stated.
	To the hospital of Attanding Physician: Tha low within 24 hours eftar deeth.  To the Funeral Director: After this certificata has completely filled in by tha funaral director, paga 2	edical	(Check only one)  Medical Examiner: On the basis of exemination and manner stated.	end/or investigation, in my opinion, death occ	curred at the time, o	date and place, and	due to the cause(s)
_	Vithir To th	×	29b. Signature eng fitte of certifier	29c. License number		29d. Date signed (M	
	/		1/4/4 -	D2539	71	8-14	-2006
	KY	ŀ	30. Name end address of person who completed cause of death (Item 23s	a) (Type, Print)	11.	0 12	allimore
	)		M. KHAN 5601- LOC	nkaven	1210	M	0" 21239
		ite	31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture				/

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Pachilis **Physician** AUGUST 1251 AM Margaret /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth Aug 17927 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Maryland 1 ☐ M 2 💢 F 217-24-4674 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Essex Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 238 10 Avenal Road 21221 U.S.A. Completed by Funeral filed within 72 hours after deeth iteme. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7. Department of Heelih and Mantal Hygiens importent: if item 27 is marked other than "na any injury or other traumatic aven" (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown William Mummert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Brooks Ave Abingdon, Maryland 21009 Carl Pachilis, Jr Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Soecify) Garrison Forest 08/14/06 Owings Mills, MD 22. Name and Address of Facility 300 Mace Ave Balto 21. Signature of Fundral Service Lice. Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or compliant shock, or heart failure. List only on Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Hypoxic Respiratory Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Neuromuccular Di Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant af time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed this certificate has been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rmed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the th 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 8, 2006 AJ4147357 who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ave, But more MD 21224 Irindade 31. Date filed (Month, Day, AUG 32. Egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fh 9838 8-15-06 vt. State of Maryland / Department of Health and Mental Hygiene 2560 For Stata Registrat 1-Certificate of Death Reg. No 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Month 30 Nonne J. Powell Physician 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Α HOS DITAL Age (In yrs. last birthday) enera If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) If Linder 1 5. Social Security Number 212 84 7345 6. Sex **Funeral** Months 1 M 2 50F 07 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: If item 27 is marked other then "natural", or itema 23a or 28e-f ehow empt injury or other traumatic event, the Medical Examinating the motified an once. Baltimore NIA 1 XYes 2 No MD Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 401 N. Butan Street Apt. 208 21201 Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) Ketau 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hughes Gilbert Nola Donell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Street Apt. 208 Batto. MD 21201 401 N. EUTayy Hameed nevelle Niece Date 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition place) 1 Burial 2 ☐ Cremation 3 Removal from State Baltimore, MD Tunitu Cemeten 4 ☐ Donation 5 ☐ Other (Specify) Vaughn Corene Funeral Services
4905 York Rd. Baltimore, Md. 21. Signature of Funeral Service Licensee 10. 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anemia severo. /Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No cate has been signed by the etten page 2 should be detached for u 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No emia, cemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 ☐ No 1□ Yes certificate Division of Vital director, 25. Was case referred to medical examiner?

↑ ✓ Yes 2 ☐ No 26. Place of Death | Check only one Be Hospital: 1 ☑Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) After this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural s efter dea... ej Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide within 24 hours e To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 12 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hiddugavu mid Mohammed

State Registrar 31. Date filed (Month, Day, Year)

5

32. Registrar's Signature

			1- For State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 2 5 6 0 1 Certificate of Death Reg. No.							25603	
	- 85		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
	Physici		Thomas	D Pa	Man			Month 8	Day Jeer	6 1100 AM	
1	/Medic Examin	_	4a. Facility Name (If not institution, give s		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4b. City, Town, or	Location of Death	-	4c. County of Dear		
			University of M	lanland Me	dical Co	nter	Baltin	ore			
	Funeral		5. Social Security Number 6. Sex 1215-66-0879	X4 2 1 E	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	(ear) Co	hplace (State or Foreign untry)	
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 Ie marked other then "naturel", or iteme 23e or 28e-f ehow any injury or other treumatic event, ite Medical Examination in 2006.		Usual Residence of Decedent	66	Yrs.			Sept 6	, 1939	India	
		Director	10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits	
			MD Howar	d		Marriott	sville			1 □Yes 2X No	
			10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?	
			1671 Henryton Ro	ad			21104		U	SA	
		Funeral	TT. Wartar States	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
36		by Fu	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 27 No If Yes, Give A	1	□Yes 2XNo	Specify:		Specify: T	ndian	
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15		piet	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of work done during most of working life. DO NOT use retired)						
212		Completed	Zį	College (1-401 3+)	Certi	fied Publ	ic Accou	ntant	Accounti	ng	
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Maryland		1	19a. Informant's Name/Relationship (Ty Mrs. Elizabeth Pal	Pe, Print) (Spouse					City or Town, State, .		
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JO.			1 XBurial 2 ☐ Cremation 3 ☐ F	emoval from State	cemetery, cren	Mem. Par			ykesville		
Baltimore,			4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License								
Ba			Sykesville, MD 21784 (410)-795-1400								
the state of	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between								
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			resulting in death)	Due to (or as a conse	equence of):	11		,			
		10	b. Metastatic non-small cellury cancer  b. Metastatic non-small cellury cancer  Due to (or as a consequence of):								
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<i>/</i>	exect en and rial-tra	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  Pathologic fracture of Carvical Spine.  Due to (or as a) consequence of):									
8760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dicai									
9		Wed	IF FEMALE:								
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<u>α</u>		P.	Part II. Other significant conditions con	ntributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
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ital		0	25. Was case referred to medical 26. Place of Death (Check only one)								
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		Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
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			30. Name and address of person who co	empleted cause of death (It	em 23a) (Type	Print)	MCCLA	111000	08/1	1000	
	10		Richard J. 1	Wright, o	22 6	uth Gre	one Str	est Ball	imare W	10	
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig		•					
	Regist	rar	AUG 1 5 2006 March & Specker								

			1 - State Registrar	State of Maryla			of Health a of Death			iene <sub>eg. No.</sub> 20	06	256	509
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			Stella Maris		Luthe	utherville Under 1 Year   If Under 24 Hrs.   8. Date of				altir		- C (	
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	Director		Usual Residence of Decedent			<u> </u>			Julie 19	, 1921	Mar	ytanu	
	yland Now		10a. State 10b. County	10c. (	City, Town or Lo	cation						10d. Inside Cit	
	e-1-el	ctor	Maryland Baltimore	Mic	ddle Riv	ver						1 🗌 Yes	2 (2XNo
	or 28	SI'e	10e. Street and Number			10f. Zip C			1	0g. Citizen of		ntry?	
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Maryland 21215-0036	al Hy roth	Be	17. Father's Name (First, Middle, Last)				18. Moth	er's Name	First, Middle,	Maiden Suman	ne)		
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Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of prec	etal death 3	Ectopic pre					te of deliventh		Year
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>	Attending Physiclen: r death ctor: After this certificator; y the funeral director.	To Be	examiner?	ospital: 1  Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Othor		me 5 ☐ Resid		ner (Speci	fv)	
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	the hin 24 the F	Medi	one)	and manner stated.		<del></del>	License number			9d. Date signe			
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	6		30. Name and address of person who cor				ттио	TTTM	MD 210	0.3			
	- 01	ate	DR. TARIQ MAHMOOD  31. Date filed (Month, Day, Year)	2300 DULA 32. Refistrar's Sig		LEI KD	• IIMUI	ALUM,	MD 210	7.3			
	Regist		AUC 1 5 20		1. h	men							

9:00 р.ш.

AUGUST 12, 2006

HERMAN PARSONS

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Designation   Continue   Contin		1- For State Registrar	Certi	ificate of Death	,,,	Reg No	5 2561
Signature of the property of t		Decedent's Name (First, Middle, Corina	Angela		Month August 6	Day Year 5, 2006	2030 hrs
215-92-4666   M 2 X 45 Y 15   More than 10 and 10 a			- ·		Location of Death		
The Revenue of Science   150 City, Town or Lineacon   150 City, Town or Li		5. Social Security Number	5. Sex 7. Age (In yrs. last		Hours Min	Foreig	
The part of the pa	Director		1 M 2 X F 45		Nov.	12, 1960 co	
Secretary   Secr	any		10c. City, To	own or Location			10d Inside City Limits
Secretary   Secr	f show	MD Anne	Arundel Gam				
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Security   Continue	with the ns 23a pe notil		12. Was Decedent Ever in U.S.	13. Was Decedent of His		lo- 14 Race - Amer	can Indian, Black,
Security   Continue	er death , or iten r must b	1 3 Widowed 4 Divor	1 Yes 2 X No			7.71	nite
Security   Continue	ours aft atural" tamine	15. Doordoollo Education (Secola	or Dates.	6a Decedent's Usual Occupati	on (Give kind of work done	0,000.11)	
Security   Continue	36 in 72 ho nan "na lical Ex	Elementary/Secondary (0-12)	College (1-4 or 5+)		DO NOT use retired)	0 11	
Security   Continue	d within ygiene ygiene other the Med	17 Father's Name (First, Middle, L	ast)		8.Mother's Name (First, Middle		<del></del>
Security   Continue	1215 lbe file ental H trked o				•		
Security   Continue	ID 2. should and M 27 is ms matic e						
Physician Medical Xaminor    23a Part   Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardade or respiratory arrest, shock or heart   Approximate Interval Between Onsel and Between Onsel Between Onsel and Between	Fe, N 1 and 2 Health Fitem 2	20a. Method of Disposition	20b. Pla	ace of Disposition (Name of cen	netery, Date		
Physician Medical Xaminor    23a Part   Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardade or respiratory arrest, shock or heart   Approximate Interval Between Onsel and Between Onsel Between Onsel and Between	Pages Pages nent of ant: If or othe		1 Temovar from otate			Queensto	wn, MD
Physician Medical Xaminor    23a Part   Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardade or respiratory arrest, shock or heart   Approximate Interval Between Onsel and Between Onsel Between Onsel and Between	Balt permit Departi Import Injury	21. Ig g u e al Service L	icensee	1	Dingletoi		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions  Sequentially list list list list list list list list		3a Part I Enter the disease, or co	omplications that caused the death. D				Approximate Interval
Due to (or as a consequence of).  Sequentially list conditions. If anyl, leading to immediate use events resulting in death) Last  University of the part of the p	/Medical	Immediate Cause (Final disease		а			
The composition of the composi	. red		Due to (or as a consequence of).				
Note   Part	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):				
Note   Part	ed nsit <b>Exam</b>	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
So VVas lates of least 12 months?    Vest 2   No 9   Vest vision of least 12 months?   1   Live birth   2   Fetal death   3   Edopic pregnancy   Month   Day   Year   Past 12 months?   1   Vest 2   No 9   Vest vision of least 12 months?   1   Vest 2   No 9   Vest v	execui an and al - tra		X AMENDED	- 27 ME -000 1	0/11/06 [77]	<del></del>	
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	760, icate be physicate burthe bur	IF FEMALE:	23c. If yes, outcome of pregna	ncy			
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	x 68 h certif tending use as	past 12 months?	4 Pregnant at time of deat	h	Ectopic pregnancy	Month E	Day Year
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	Boy the death of the death of the attraction bed for bed for buys of the state of t	1 Yes 2 No 9 V Unkn	9 Olikilowii		Data Data		
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	P.O. ss that to gened by the detac		contributing to death but not resi	uiting in the underlying cause gi			
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	rds, require been si should t						
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	Reco				peri	formed? death?	
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	cian: Certific ector, p	25. Was case referred to medical examiner?	Hospital		Othor: -		
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	of Vi	1 Yes 2 No	inpatient 2 E		Transmig Transmig		Scene
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	ion c tending eath. or: Af the fun	1 X Natural 5 Pendir	(Month, Day,Year)				
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	it or At after d	3 Suicide 6 Could	not be 28e Place of Injury - At hom	ne, farm, street, factory, office bu			ral Route Number, City
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	Hospitz 4 hours Funera ely fille	29a Certifier	(Opeciny)	death occurred at the time da	te and place, and due to the car	use(s) and manner as start	red
29b Signatore and title of certifier  29c License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 7, 2006	To the loughin 2	one) 2 Medical Exam	iner:On the basis of examination and				
30 Name and address of person who completed cause of death (Item 23a)	Ž	29b Signatore and title of certifier	Nanna.				nth, Day, Year)
		curat	the completed cause of death (Item 2)			August 7, 2006	
		30 Name and address of berson w					
State 31. Date filed (Month, Day, Year)  Registrar AUG 1 5 2006 32 Registrar's Signature				11 Penn Street, Baltimo	ore, MD 21201		

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

06-05745 Demario Queen

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certifica	te of Death	Reg N	<u>. 2006 2561</u>
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)			2. Date of Death  Month  Day  August 4, 200	7 Year 0931 hrs
. 1	4a Facility Name (if not institution, give 400 Pamela Road #F	street and number)	4b. City, Town, or Location of Dea Glen Burnie	ith	4c. County of Death Anne Arundel
Funeral Director		7 Age (In yrs. last birth	day) If Under 1 Year If Under 24H  Months Days Hours M  Yrs		M/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
re Maryland or 28a-f show any fred at ouce.	Usual Residence of Decedent  10a State 10b. County  Maryland Anne Ar	undel Glen	Burnie		10d Inside City Limits 1 Yes 2X No
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 400 Pamela Rd.		10f. Zip Code 21061		itizen of What Country? USA
death wi or items must be	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ever in U.S Armed Forces?  1 X Yes 2 No If Yes, Give Year	Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Puer      Yes 2X No specify:		14. Race - American Indian, Black, White, etc.  Specify Black
: -	15 Decedent's Education (Specify on Elementary/Secondary (0-12)	College (1-4 or 5+)	ecedent's Usual Occupation (Give kind o uring most of working life. DO NOT use n laims Adjuster	etired)	o. Kind of Business/Industry  Crie Insurance
15-003 filled within the Hygiene and other the true Med	12th 17 Father's Name (First, Middle, Last)	2,110	18.Mother's Nar	me (First, Middle, Maid	en Surname)
e, MD 21215-0036  I and 2 should be filed within Health and Mental Hygiene ritem 27 is marked other tha r traumaric event, the Medic	Edward W. Queer 19a Informant's Name/Relationship (Ty   Delorma Goodwyr	pe, Print ) 19b	Mailing Address (Street and Number of		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by I	20a Method of Disposition  1 X Burial 2 Cremation 3  4 Donation 5 Other Specify:	Removal from State 20b Place of cremate Best	Disposition (Name of cemetery, ry or other place) gate Memorial Park and Veterall	1	c Location - City or Town, State
_ ====	21. Signature of Funeral Service Licens  Lavy H. Rees		22 Name and Address of Facility Wm. Reese & So 821 West St. A tenter the mode of dying, such as cardial	ns Mortua nnapolis,	ry, P.A. Md. 21401 shock, or heart   Approximate Interval
Physician /Medical Examiner	failure List only one cause on ea  Immediate Cause (Final disease a.	ch line.  Cocaine intoxication  Due to (or as a consequence of):	only the mode of symig each ac cardia		Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):			
executed an and al - transit	events resulting in death) Last  d.	Due to (or as a consequence of):			
freb, ficate be executed g physician and the burial - transit	IF FEMALE:	23c. If yes, outcome of pregnancy	rFH, 23a,27,28a-f,perME		23d Date of delivery
). Box 687 the death certification by the attending cheed for use as I Physician/	23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pres	gnancy	Month Day Year
cords, P.O. Box 68 law requires that the death certif has been signed by the attending 2.2 should be detached for use as moleted by Physician	`	contributing to death but not resulting	in the underlying cause given in Part I.	1 Yes 2	co use contribute to the cause of death?  No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box 68 within 24 hours after death prystian. The law requires that the death certif or the funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as redical Certification: To Be Completed by Physician				24a. Was an autopsy performed	
ital Recician: The last certificate herector, page	25 Was case referred to medical	ospital:	26 Place of Death (Che		
f Vit		i inpatient 2 ER/Ot	Itpatient 3 DOA Null Null Null Null Null Null Null Nul	rsing Home 5 Res	idence 6 Other Scene
Division of V spiral or Attending Phy norus after death nearal Director: After the filled in by the funeral Certification: To	1 Natural 5 Pending 2 Accident Investigati	Fnd 8/4/2006 Fnd	1 9:25 am Yes 2 X No	unk	et and Number or Rural Route Number. City
Divisoppital or / pospital or / pours after meral Dire / y filled in t		(Specify) house		or Town, State Glen Burn	ie, MD
To the Hospital within 24 hours For the Funeral completely filled	(Check only one) 2 Medical Examiner  29b. Signature and title of certifier.	an: To the best of my knowledge, dea :On the basis of examination and/or II and manner stated.	ath occurred at the time, date and place, any opinion, death occurred at the time, date and place, any opinion, death occurred at the time, date and place, and opinion, death occurred at the time, date and place, and opinion of the time, date and place, and opinion of the time, date and place, and opinion of the time, date and place, and opinion of the time, date and place, and opinion of the time, date and place, and opinion of the time, date and place, and opinion of the time, date and place, and opinion of the time, date and place, and opinion opinion of the time, date and place, and opinion opin	ed at the time, date and	place, and due to the cause(s)  Od Date signed (Month, Day, Year)
	layoute In	e While	O.C.M.E.		ugust 5, 2006
1			111 Penn Street, Baltimore, M	D 21201	
Stat Registra	11 11 7 7 1 11	32 Registrar's Signature	Sparke		

			For State of Ma 1 - State Registrer	•	epartment of F Certificate of			giene	06	25612
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea	ith Day	2886	3. Time of Death
	/Medic	cal	Thomas H. Russell  4a. Facility Name (If not institution, give street and number)	Jr.	4b City Town o	or Location of Death	Augus	4c. County		1,7 / AM
	<b>Examir</b>		Baltimore-Washington Medical	l Center		Burnie		1	Arund	de1
	Funeral Director		5. Social Security Number 6. Sex 7. Ag  229-40-3231  Usual Residence of Decedent	e (In yrs. last birtho 70 Yr	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 8	Year) 1935	9. Birthpla Countr Virg	ace (State or Foreign ry) inia
	ehow	'n	10a. State 10b. County Maryland Anne Arundel	10c. City, Town o					10	0d. Inside City Limits
8	with the M a or 28a-f ke notifie	Directo	10e. Street and Number 30 Nicholson Drive	Tasade	10f. Zip Code	21122		10g. Citizen of V USA		
Thomas	DESILITIOTE; INIGITY ISING ZIZID-UDDO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Examinat must be notified at ance.	y Funeral Director	11. Marital Status  1 Never Married 2 Married 1 12. Was Decedent Armed Forces?  1 Never Married 2 Married 11 Yes, Sive 1	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)		e - America ck, White, et	itc.
, [	2-UU30 72 hours aft hatural', or	eted by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. D	Decedent's Usual Occup Give kind of work done ife. DO NOT use retired		ing	16b. Kind of Bu	**	hite
	d within /giene.	Completed	Elementary/Secondary (0-12) College (1-4or s	o+)	ife. DO NOT use retired	d) -		Marylan	d Dry	dock
455E	Maryianu Z nd 2 should be filed th and Mental Hygi 27 is marked other traumatic event, II	Be	17. Father's Name (First, Middle, Last)  Thomas H. Russell Sr.			18. Mother's Name	e (First, Middle, Jones	Maiden Sumam	18)	
22	aryid should and Men s marke	10	19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street			r, City or Town,	State, Zip (	Code)
	and 2:		Patricia L. Russell (wife)	30 20h Bloss et F	Nicholson	Dr. Pasad	dena, Ma			
	ages 1 int of H t: # ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Name of crematory or other place Hill Cemete			20c. Location -		vn, State lary1and
	Dallinofe, permit. Pages 1 ar Depertment of Hea Important: if Item any Injury or othe		21. Signature of Funeral Service Licensee  Kevin E. 1		22. Name and Addre	ss of Facility				ar yrand
					McCu11y-Po 3204 Mount	tain Road	Pasade	na Mar	yland	21122 Approximate
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition resulting in death)	itocel	lular (	Carcin		rest,	1	Interval Between Onset and Death
	Examiner			a consequence of)	):					
Ty	d d ansit	Examiner	if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that mittated events c.	a consequence of)	):					
9	tificate be executed in physicien and as the burial-transit	sal Exe		a consequence of)	:				- 11	
	rtificate ng phy	Medical	IF FEMALE:							
	Attending Physician: The law requires that the death certificate be executed reash.  Attending Physician: The law requires that the death certificate be executed cleath.  Actor: After this certificate hes been signed by the ettending physician and the funeral director, page 2 should be deteched for use as the burial-transit	Physician/M	23b Was decadent pregnant 23c. If yes, outcome	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	,		23d. Dat Mor	te of delivery nth D	y Day Year
0	wrequires that the team of the	Þ	Part II. Other significant conditions contributing to death b	ut not resulting in t	he underlying cause giv	ren in Part I.			ribute to the	e cause of death?
2	Invision of vital necology, r.C. for attending Physicien: The law requires that the defect death.  Director: After this certificate hes been signed by the funeral director, page 2 should be detached.	Completed					24a. Was a autopo perfor	med?	Were autops prior to comp death?	sy findings available pletion of cause of
	ysician: The lis certificate he director, page	Be	25. Was case referred to medical examiner?	T100	ations all pool Oth	26. Place of Death				
1	ding Phys h. After this funeral di	ion: To	27. Manner of Death 1 Natural 5 Pending (Month, Da		ne of ury 28c. Injur	4   Nursing Ho	me 5 Resid			)
	2 g g z	Certification:	e Could got be	ury - At home, farm c. (Specify)	n, street, factory, office		28f. Location (S City or Town	treet and Numb n, State)	er or Rural i	Route Number,
	Hospite 4 hours Funeral	Medical Co	29a. Certifier (Check only one)  1 Certifying Physicien: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/	death occurred at the tir or investigation, in my o	me, date and place, opinion, death occurr	and due to the c	ause(s) and ma date and place, a	nner as star and due to t	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	M 17	29c. Licens			29d. Date signed		
	8		30. Name and address of person who completed cause of d	eath (Item 23a) (T	ype, Print) 30/ Hasp	ital Dri	ve, Gle	n Bur	nie, t	10, 2006
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 5 2006  32 Registr	eath (Item 23a) (1)	porte					

			1 _ State	State of Maryland		artment of H			2006	25613
			Ragistrar  1. Decedent's Name (First, Middle, Last)		061	inicate of t	Jeani –	2. Date of Dea	Reg. No. 👇 🔾 🔾 🔾 ath	3. Time of Death
	Physici		Gerald I	E. Reinecke				ANGUS	T 10 2000	10-01
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of Dea	J
			SINA HOSPITAL	OF BALTIMU	LE	BALTIM	ORE C	-174		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th y, Year) 9. Bir Co	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	6	53 Yrs.			10/8/	1942 Mar	yland
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary I sh	to	MD Harford	Be	el Ai	r				1 ☐ Yes 2 ☑ No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	23a c		214 Kings Crossi	na Circle	1B	21	014		us	a
	tement des	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No o Rican, etc.)	- 14. Race - Ame Black, Whit	
36	s afte	by Fi	1 Never Married XXMarried 3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:		1 □ Yes 2√D4No	Specify:		Specify: W	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or iteme 23a or 28a-f show aumatic event, the Mudical Exprairant rotal be notified at	edt	15. Decedent's Educa		16a, Deced	dent's Usual Occupa	ation		16b. Kind of Business	
75	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done o	during most of wor	rking	Lucen	
7	d with giene grene	E O	12	College (1º40/ 3+)	S	upervis	or		Technolog	ал
b	be filed at hygie of other	Be (	17. Father's Name (First, Middle, Last) Charles E. Re	ni noako					Maiden Surname)	
<del>Z</del>	should and Men	မ					Hazer	I. Dur	ncan	
Maryland	d 2 sh h and 7 le m traum		19a. Informant's Name/Relationship (Typ		19b. Mailin	ig Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town, State, a	Zip Code) 21014
	permit. Pages 1 and 2 should Department of Heelth and Men Important: If Item 27 is marke eny injury or other traumatic QDCB.		Barbara M. Reine	20b. Pla	214 ice of Dispo	Kings (	Crossin	g Circl	e 1B Bel 20c. Location - City or	Air MD
ē		20a. Method of Disposition    Second State   20c. Location - City or Temperature   20c. Location - City or T								
altimore,			21. Signature of Funeral Service Licenses			. Name and Addres	- 15,		PARKVII. 8800 Harfo	
ä	Ded Fig.		114.50.5	UL.	E	vans Fur	neral C		arkville	MD 21234
			23. Part). Enter the disease, or complic shorts, or heart failure. List only one	ations I t caused the death.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	REFRACTOR						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque		01-312				(D) 12 12
	Cxammer	_	Sequentially list conditions, b.	In the second second second second	100000					
	led nsit	nlner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a sonseque	nee or).					
	be executed sicien and burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):					
8760	cate be executed physicien and the burial-transit	dical	a.							
9	tificate og phys as the	led								
ŏ	eath certifi attending p for use as	an/N	230. Was decedent pregnant	c. If yes, outcome of pregnan	cy death 3.⊡	Ectopic pregnancy			23d. Date of del	
O. Box	at the death certifi by the attending   tached for use as	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of dea 9☐ Unknown		Other (specify)			Month	Day Year
۵.	hat thick do by detach	by Physician/Me	Part II. Other significant conditions conti	obuting to death but not recul	ting in the ur	adorhioa sausa ana	on in Bart I	23o Did to	bacco use contribute to	the cause of death?
Division of Vital Records,	The law requires that tte has been signed b page 2 should be deta			NCER.	ang in the di	idenying cadse give	minirani.			obably 4 Dunknown
202	w require been si should t	Completed	-	DENIDANT	0100	Lette on	FILE			
æ	: The law cate has l	m d		1	IJ (Pri	) CIES I	ELLITE	pertor	med death?	topsy findings available completion of cause of
ta		Be C	HYPERTENSI  25. Was case referred to medical	01			26. Place of Dea			2. No
<u>=</u>	Physician: this certific al director,	To B	examiner?	ospital:	R/Outpatien	t 3 DOA Othe	AC.		lence 6 Other (Spe	cify)
0	ding Ph. h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ow injury occurred	,,
Sio	eath. or: A	catle	2 ☐ Accident investigation				Yes 2 □ No			
$\frac{2}{5}$	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or Rum, State)	ıral Route Number,
	pital		29a. Certifier 1 Certifying Physi	cian: To the best of my know	ladge death	cooursed at the term	a data and place	and due to the		
	24 h	Medical	(Check only 2 Medical Examine one)	er: On the basis of examination and manner stated.	on and/or inv	estigation, in my or	pinion, death occur	rred at the time, o	date and place, and due	to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Monti	h, Day, Year)
	. 1		Marin	Cm		RES-	000	F	AUGUST 10	2006
1	01/		30. Name and address of person who com							
	1		MABEL LOBER		SIM	im Hu	SPITAL	OF P	ALIMOR	2
7	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	Le A	P.N.				
			AUG 1 5 200	JO   600 000 05 0 1	Cr. Ca	DE SELLE				

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	For State Registrar	State of Maryland / Dep <i>Ce</i>	artment of Health and rtificate of Death	Mental Hygie Reg.	6000	25614
	Decedent's Name (First, Middle, Last)			2. Date of Death	Da., V	3. Time of Death
Physician /Medical	Nancy Jane Rig	gleman		August 12	, 2006 Year	7:05 a M
Examiner	4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	
	2722 Yarnall Road		Baltimore		N/A	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday  M 2 TXF 62 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.	(Month, Day, Ye	ar) 9. Birthpl	
Director	Usual Residence of Decedent	02		Dec. 13,	1943 Ma	ryland
land w	10a. State 10b. County	10c. City, Town or L	ocation		10	Od. Inside City Limits
Mary feb	MD N/A		Baltimore			1X Yes 2 ☐ No
vith the Mar or 28a-fel be notified Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
N with	2722 Yarnall Road		21230		United St	ates
fler death v	11. Marital Status	2. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - America Black, White, 6	
or the	1 ☐ Never Married 2 📉 Married	1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2 No Specify:	to mount, oto.,	Specify: Whi	
ural', o	3 Widowed 4 Divorced	Year or Dates:				
ed within 72 holygiene.  Tr. the Medical is.	15. Decedent's Education (Specify only highest grade	completed) (Give	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 16b	. Kind of Business/Inc	lustry
Mithin Mithin	Elementary/Secondary (0-12)	College (1-4or 5+)			<b>5</b>	
Thed Tygie It. Co	8 17. Father's Name (First, Middle, Last)		Warehouse	me (First, Middle, Maid	Printi	ng
d be fill the day of the control of						
should nd Men marke marke	19a. Informant's Name/Relationship (Type	e, Print) 19b, Mail	ing Address (Street and Number or Ri	rgaret Wimi ural Route Number, Ci	The second second	Code)
nd 2 state at the  Ralph J. Riggleman		2 Yarnall Rd., Ba			·	
Head Head other	20a. Method of Disposition	20b. Place of Disp	osition (Name of		Location - City or To	wn, State
age ent o	Buriai 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State MD Verer	ans Cemetery 8-1	6-2006 Ci	rownsville	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If time 27 is marked other than "natural; or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Exeminar must be notified at page.  To Be Completed by Funeral Director	21. Significant of Funeral Service Licenses		Anne and Address of Facility Am			
Depa Impo eny ii	( Class Ulmor )		328 Sulpur Spring			
CHECKE,	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not en				Approximate Interval Between
Physician	Immediate Cause (Final	Mod - 1 1	CASSICUL C	Mere		Onset and Death
/Medical	disease or condition resulting in death)	Due to (or as a consequence of):	CAINICAL C	Une		( 2 MCN/10
Examiner	Conventially liet conditions					
ner a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
executed in and ial-transit	Cause (Disease or injury that initiated events resulting in death) Last					
		Due to (or as a consequence of):				
cate be executed physicien and sithe burial-transit	d.					
ding g		c. If yes, outcome of pregnancy			004 0	
ath o ath o for us	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetel death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
at the death cert by the attending letached for use a	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				
iries that the death certification is signed by the attending doe detached for use a dispersion by Physician/Me		ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
uires ti				1 🗌 Yes	2≹No 3□Prob	ably 4 □Unknown
The law requires to has been single has been single 2 should Completed				24a. Was an	24b. Were autor	osy findings available
he lav e has age 2 a			·····	autopsy	prior to con death?	npletion of cause of
e C. p	25. Was case referred to medical		26 Place of De	1 Yes 2   ath Check only one	No 1 ☐ Yes	2 (25) No
ysicii s cer direct	examiner? 1 ☐ Yes 2-5XNo	spital:	Other	nome 5 Residence	6 Other (Specify	)
g Phy Berthi Berat	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at Work?	28d. Describe how i		
athoria	1 → Natural 5 → Pending 2 → Accident investigation	(Month, Day 1 oar) Injury	M 1 Yes 2 No			
tel or Attending F:s after death. el Director: After ed in by the tuner: Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
Cer   Cer						
Hosp 4 hou Funa ely fii	29a. Certifier Certifying Physi (Check only 2 Medical Examine	cian: To the best of my knowledge, dea er: On the basis of examination and/or i	th occurred at the time, date and place envestigation, in my opinion, death occ	e, and due to the causeurred at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
To the Hospital or Attending Physician: The law requires that the death certification is 4 house long the triangle of Attending Physician: The law requires that the death certificate that the function is completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Me	one) 29b. Signature and talk of continger	and manner stated.	29c. License number		Date signed (Month, I	
To To	200. Digitatora and mo of Continue	11/2/-	100	- A	, ,	1 2000/
/	( ( Emi)	O) at	0/)///	) Hu	1945T 19	, was
5	do name and address of person who con	ppleted cause of death (Item 23a) (Type	Print) S. Haraver St.	Rath	ace, not -	1225
State	31. Date filed (Month, Day, Year)	32 Aegistrar's Signature	3, 14 × (1/4 ) 1	) Malica	J/ U- 2	
Registrar	Aug 1 5 200	1 Elegen Li	ALC: NO.			

# Please Type or Print in Black Indelible Ink

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Physicia	ın/	Decedent's Name (First, Mide							ate of Death		Year	3. Time of Death
ledical Exami		Justin  4a. Facility Name (if not instituti	Michae	1	14	Romber			nonth E		ty of Death	0945 hrs
and many		Baltimore Washingto				Glen Burn		Death			Arundel	
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. las	t birthday)	If Under 1 Ye			Date of Birth(	MM/DD/YY	YY) 9. Birti Foreigi	nplace (State or
Director		212-13-2507 Usual Residence of Decedent	1 X M 2 F	21	Yrs.	Months Da	ays Hours	Min.	July 29	1985		intry) MD
ɗaryland 28a-f show any 1 at once.		10a. State 10b. County		•	own or Location	on						10d. Inside City Limits
faryland 28a-f sho at once.	į	MD Anne  10e. Street and Number	Arundel	Pasa	adena	10f. Zip Code			100	Citizon of	What Coun	1 Yes 2 X No
th the Mar 23a or 28s notified a	Dire	7741 Edgewood	Avenue			·	1122		109		S. A.	
th with tems 23 st be no	Funeral	11. Marital Status 1 X Never Married 2	12. Was Decedent Armed Forces?			Decedent of Fes, specify Cub				14. Ra	ace - Americ	can Indian, Black,
fter des I", or i			vorced If Yes, Give Year or Dates:	X No	1	Yes 2X	No specify:			Specif	y. Whi	te
hours a natura Examir	ed by	15. Decedent's Education (Sp.	ecify only highest grade com			's Usual Occup est of working li			done 1	6b. Kind of	Business/Ir	ndustry
n, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12 1 2	College (1-4 or 5	+)	•	Plumber		,		Р1	umbin	ø
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media		17. Father's Name (First, Middle	•					•	st, Middle, Ma	iden Surna	me)	-
212' ald be Mental marke	To Be	Michael Rando	-	_	19b. Mailing	Address (Str			Jorge Route Number		own. State.	Zip Code)
MD nd 2 sho alth and m 27 is		Mrs. Karen Anı			7741 1	Edgewoo	d Aven		asaden	a Mar	yland	21122
O 등 플 플 필		20a. Method of Disposition  1 Burial 2 X Crematic	n 3 Removal from Sta		ace of Disposi ematory or oth	tion (Name of o	cemetery,	<sub>Da</sub> Augus	te 2	20c. Locatio	on - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	Specify:	Ch		ce Crem	ation	200	6	Steve	nsvil	le, MD
Balt permit. Departr Import injury		Mink A.	arun	Mois	357 1 8	Second .	Avenue	Sing SW G	leton . len Bu:	Funera rnie.	al Hon MD 2	me, P.A.
Physician /Medical		23a. Pat I. Enter the disease, of failure. List only one caus	r complications that caused	the death. [	Do not enter th	e mode of dyin	g, such as ca	rdiac or res	piratory arrest	t, shock, or	heart	Approximate Interval Between Onset and
Immediate Cause (Final disease or condition resulting in death)  a. Methadone intoxication  Due to (or as a consequence of):										Death		
		Sequentially list conditions,	b									
_	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.								- 02	
cuted nd transit		events resulting in death) Last	Due to (or as a conse	quence of):	:							
760, Grate be executed g physician and the burial - transit	Medical	X UNPENDED	_ AMENDED ite	m#23a,	27,28a-f	,perME,g	858 <b>,</b> 8/19	)/06 TT	1			
8760, ifficate be ig physical		IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outcom	e of pregna	,	al death 3	Ectopic	pregnancy		23d. Date Month	of delivery	ay Year
O. O. Box 68760, that the death certificate be even the death certificate be even by the attending physician detached for use as the burial	Physician/	past 12 months?  1 Yes 2 No 9 Ui	4 Pregnant at death Unknown	time of		er (Specify)		,,				.,
O. B at the da by the tached I		Part II. Other significant cond		but not res	sulting in the u	nderlying cause	e given in Par	t I.	23e. Did toba	acco use co	ntribute to t	he cause of death?
s, P.O.	d by								1 Yes	2 No	3 Prob	ably 4 🗸 Unknown
cords, I aw requires nas been sig 2 should be	Completed								24a. Was an autopsy		prior to co	opsy findings available ompletion of cause of
of Vital Recoing Physician: The law After this certificate has uneral director, page 2 si	E CO								perform 1 Yes 2		death? 1 ✔ Ye	s 2 No
ital sician: s certif rector	å	25. Was case referred to medic examiner?	Hospital:	nt 2	R/Outpatient		ce of Death (0	Nursing Ho		esidence 6	Othor	
1 of Vital Recting Physician: The After this certificate funeral director, page	٦ ا	1 Yes 2 No 27. Manner of Death	28a, Date of Injur	v 2	28b. Time of Ir		njury at Work?		. Describe ho			
ion ttendin feath. for: A	atior		iding (Month, Day, Your Stigation) Fnd 8/11/		Fnd 6:36	pm 1	Yes 2 X	No uni	k			
The law required in the la							factory, office building, etc. 28f.			eet and Nur te) 7741 MD	mber or Rur Edgewo	al Route Number, City od Ave.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - trans	Medical Co	29a. Certifier (Check only 1 Certifying F	Physician: To the best of my aminer: On the basis of exan and manner stated.	knowledge				e, and due				
F × F S	Me	29b. Signature and title of certif					nse number					th, Day, Year)
		20 Name and address of	n who completed cause of d	oth (Item 0	330)	0.0	C.M.E.			August 1	3, 2006	
			sistant Medical Exam	iner 1	11 Penn S	treet, Baltin	nore, MD 2	21201				
St Regist	ate rar	31. Date filed (Month, Day Year AUG 1 5	2006 32 egistrar	's Signatu	Apa	4						
					- N.					_		

		,	1 - For State Registrar	State of Ma	ryland / Depa	artment of I	Health and Death		giene? 006	25616
	物物 。"	1/4	1. Decedent's Name (First, Middle, Las					2. Date of De Month		3. Time of Death
	Physici /Medic		Billie Ma	e Ree	d			August	10 2006	3:08 P M
	Examin		4a. Facility Name (If not institution, give				or Location of Dea	ath	4c. County of Dea	
			1111 Rosehill Av	enue		_	rstown		Washin	igton
	Funeral		5. Social Security Number 6. S 216-34-7590	ex 7. Age ☐ M 2 ☐ XF 7	(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days		1. (Month, Da	h 9. Bir y, Year) C	nthplace (State or Foreign country)
	Director			7	115.			Januar	y 31 1935	Virginia
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	9 within 72 hours after death with the Maryland liene. r than "natural", or Itama 23a or 28a-f show Ita Medical Examinar must be notified at	5	Maryland Washi	naton	Hagon	a+ aa				1 ☐ Yes 2 ☐ <b>X</b> No
	28a-1	Director	Maryland Washi	ng ton	Hager:	10f. Zip Code			10g. Citizen of What C	Country?
	with De or			17		Tot. Zip Gode	04704			
	ath a 23	rai	1111 Rosehi	12. Was Decedent E		Man Danadani of	21704	(Casefu Vac or Na		JSA origan ladian
	er de Itam	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marned	Armed Forces?		If Yes, specify Cub	oan, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	Black, Whi	
36	s aft	by F	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:	,	1 ☐ Yes 2 No	Specify:		Specify:	white
8	tura	be	15. Decedent's Ed		16a Dece	dent's Usual Occu	nation		16b. Kind of Business	
21215-0036	C * 2	Completed	(Specify only highest gra	ide completed)	(Give	kind of work done DO NOT use retire	during most of w	rorking		,
12	filed within Hygiene. other then "	E C	Elementary/Secondary (0-12)	College (1-4or 5+ +1	Geriatric Nursing Asst.					20
9	be filed stal Hygie of other		17. Father's Name (First, Middle, Last,			aci iaci			Maiden Surname)	
Maryland	D a D	o Be	John	Sh	annon		Flo	nra	м на	arrison
7	should ind Meni	F	19a. Informant's Name/Relationship (			na Address (Stree	1		er, City or Town, State,	
Z	d 2 sho th and t7 is mu traum		William Reed	son	1.	111 Posoh	oill Avo	Hazanet	own MD 2170	4.4
	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition	3011	20b. Place of Dispo	sition (Name of		Date	20c. Location - City or	
סר	nt of nt of : if it		1 🔀 Burial 2 ☐ Cremation 3 ☐		,	matory or other pla		4.7. 6	000 0	•=40 = 122 to m (22) (0)
ij	permit. Pages Department of findortant: If Ite any injury or of		4 □ Donation 5 □ Other (Specification of Funeral ervice Light Light 1997)		Maryland	Veterar  Name and Addr	is cem. F			/ille Marylan
Baltimore,	Department of the partment of		21. Signatur of Funeral Brylo Liger					Stalling	s Funeral H	
	20240		m d					Road Pasa		122 Approximate
			23a. Part . Enter the disease, or comshock, or heart failure. List only	one se o ach line	ene death. Do not en					Interval Between Onset and Death
	Pnysician	10	Immediate Cause (Final disease or condition resulting in death)	a Hitrah	leani	chola	MIDCO	Samo	na	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		J			
	Examine	L	Sequentially list conditions,	b						
	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	and tran	сап	that initiated events resulting in death) Last	C. Due to (er ee e	consequence of):					
50,	death certificate be executed e attending physician and of for use as the burial-transit			Due to (or as a	consequence or).					
8760,	hysic the b	lcat		_d						
9	ing pt	Med	IF FEMALE:							1
Вох	eath certifi attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 pronths?	23c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnanc	су		23d. Date of de Month	Blivery Day Year
	he al	20	1 ☐ Yes 2 No	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death 5[	Other (specify) _				, , , , , , , , , , , , , , , , , , ,
P.0	at the de I by the a stached	h.	9 □ Unknown							
	The law requires that the tie has been signed by thoage 2 should be detache	by	Part II. Other significant conditions	ontributing to death but	t not resulting in the t	inderlying cause gi	iven in Part I.		obacco use contribute t	
ord	v require been sig should t							. 10	Yes 2 No 3 P	robably 4 Unknown
Records,	e law re has be je 2 sh	Completed						24a. Was	an 24b. Were a	utopsy findings available completion if cause of
ď	The late has page	E							rmed? death? 2XNo 1 ☐ Ye	~
Vital	ilcian: Th certificate rector, pag	0	25. Was case referred to medical	712000			26. Place of D	eath (Check only		
>	Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatien	nt 2 ER/Outpatre	nt 3 DOA	ther: 4 Nursing	Home Resi	dence 6 Other (Spe	ecify)
o		n: T	27. Manner of Death	28a. Date of Injury (Month, Day	Zab. Time o	of 28c. Inju	iry at	28d. Describe	how injury occurred	
ior	불무중호	핥	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year) Injury		Yes 2 □ No			
Division	Attendir death.	=	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injul	ry - At home, farm, st	reet, factory, office		28f. Location (	Street and Number or R	Rural Route Number,
Ö	at or At a after d I Direct d in by	Certification:	4 [] Hollicide	building, etc.	. (Зреспу)			City of 10	wii, State)	
	spital		29a. Certifier Certifying Pl	nysician: To the best of	f my knowledge, dear	h occurred at the t	ime, date and pla	ce, and due to the	cause(s) and manner a	is stated.
	P Ho Fu	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner stat		vestigation, in my	opinion, death oc	curred at the time,	date and place, and du	e to the cause(s)
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mon	ith, Day, Year)
	-		1	1/01/		Troo	6356	0	2/11/01/2	
	10		30. Name and address of pers in who	com leted cause of de	ath (Item 23a) (Type	Print)	- )-0		01.110	0 -
	10		JOHNS MOPKINS,	600 N. W	10 UFE ST	- BAR	6356 70., MD	2128	7 IMOTH	4 M. PAWUK
3	St	ite	31 Date filed (Month, Day, Year)	Registra	r's Sig (ure	We .	1/00	······································		
	Regist		AUG 1 5 200	16 Barrer	10 1	2119				

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 11:20 PM<sub>M</sub> August 10, 200<sup>Year</sup> **Physician** John J. Risser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month Day, Year) 11/09/1919 Birthplace (State or Foreign PA 5. Social Security Number **Funeral** 1**☑** M 2□ F 179-12-5314 Director Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes ŽŽNo Montgomery Kensington Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 0 20895-4301 Knowles Avenue USA or Itams 23a filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes. Give Year or Dates: 1941-61 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Caucasian ģ 3 Nidowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Military College (1-4or 5+) Elementary/Secondary (0-12) other then Supply Officer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If Item 27 is marked other th eny Injury or other treumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Fanny Brubaker 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Sue Gallagher/Daughter 8517 Gavin Manor Ct. Chevy Chase, MD 20815-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Chesapeake Crematory Aug. 12, 2006 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Rapp Funeral & Cremation Services PW1358 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Physician /Medical Coronary Artery Disease Examiner Sequential v list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). X ate has been signed by the attending physician and X page 2 should be detached for use as the burial-transit Hypertension Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Congestive Heart Failure Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Parkinson's, Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2℃ No 1 Yes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2√ No DOA patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; nerel Director: After filled in by the funera 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 To the Hospital o within 24 hours af To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Undedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title d certifier 29c. License number Aug. 11, 2006 D53691 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson Democracy Blvd.Bethesda, MD 20877 Ajay Reddy 6320 2. Registrar's Signature 31. Date fited (Month, Day, Year) State AUG 1 5 2006 Registrar

Lockind 8/10/

John Riller

State of Maryland / Department of Health and Mental Hygiene [ 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Sadler Year **Physician** 1708 Dovis 10,2006 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Piksville BALTIMORE NUISING Home AUGSburg Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 13, 1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months 214-20-0608 1 M 2 F 0 Yrs. Director Usual Residence of Decedent filad within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at MD 1 Yes 2 No PARKville BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21234 9510 KIDGLey Ave Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2☐No Yes, Give 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 WhiTe Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) parmit. Pagas 1 and 2 should be filt Department of Health and Mental Hy Important: If tiem 27 Is marked oth any injury or othar treumatic event 2008. KOESTER Leng Shipley William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9510 RIDGLEY AVE BALFO. MS 21234 BARBARA COSCIA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 8 15 06 1-Burial 2 ☐ Cremation 3 ☐ Removal from State BAlto. MD. Cem. CAKLAWN \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
PAUL STRUA PUNERAL HOME, PA
7527 nonford RO. Bilto Ma 21234 21 Signature of Funeral Service Licensee Jarl Stella Approximate Interval Between Onset and Death 23a. P. nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Athenosderatic **Physician** Vascular Cevebra Pavs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a donsegrence of) physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical detached for usa as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ♠No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? completely filled in by tha funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown After this certificata has baen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🔲 Yes 21 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: AND Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 -Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D3777 Jugust 11,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterstown 57. Main Suite 200 7115-6115 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

DHMH 17 Rev 1/2001

	1	For Amend #1 Per	Phy G858 8/15	Certificate of	Death	Reg. N	lo.	
Dhunini		1. Decedent's Name (First, Middle, Last)			17		ay Year	3. Time of Death
Physici /Media	cal -		nate Ronald	Scheeler			200G	
Examir	lei	4a. Facility Name (If not institution, give s University of Marry	land Medical	ada Balt			tc. County of Death	
Funeral Director		213 34 0377	7. Age (In yrs. la	st birthday) If Under 1 Year Months Days		Date of Birth (Month, Day, Yea)	1937 Mar	nplace (State or Forei untry) y land
A ==	1	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Lim
e a	to	Maryland n/a	Ва	ltimore				1 ∏XYes 2 □ I
1 28a	lrec	10e. Street and Number		10f. Zip Code			Citizen of What Co	-
23a c	aiD	1418 Cooksie Stree		21230			ted Stat	
ntal Hygiene. ed other than "naturel", or lteme 23a or 28a-1 show event, itte Medical Examiner must be notified at	y Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☼ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.\$ Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
"nature	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/	Industry
ygiene. er than t, the M	Comp	Elementary/Secondary (0-12) 11 years	College (1-4or 5+) n/a	Foreman	18. Mother's Name (	Sin Adiddle Meid	Domino	Sugar
h and Mental Hygiene. 7 Is marked other than " traumatic event, tra Mes	To Be	17. Father's Name (First, Middle, Last) Ellsorth Sheeler			Evelyn N.		en Sumame)	
and N		19a. Informant's Name/Relationship (Ty		19b. Mailing Address (Street				lip Code)
leelth im 27 her tr		Mary Lou Scheeler 20a. Method of Disposition		1418 Cooksie	Dat LIN		Location - City or	Town, State
nt of t t: # fe r or ot		1 X Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	ometery, crematory or other pla ar Hill Cemete	ce)		ooklyn Pa	
Department of Heelth and Menta Important: If Item 27 Is marked eny injury or other traumatic evonce.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			ess of Facility Olyniak Fun Ct Ave. Bal			IK, IID
		23a. Part Lenter the disease, or compli	ications that caused the death	130 E. FO1  Do not enter the mode of dy	ng, such as cardiac or	<u>clmore</u> , respiratory arrest,	MD 21230	Approximate Interval Between
ysician Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)		Premonies	Bacter	emie /	Sepsis	Onset and Death
aminer	ē	Sequentially list conditions, if any, leading to immediate		. Ischance	and New	ciro		
and II-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	stinel Bla	-dins			
physicien and the burial-transit	dicai E	L.	. Hypotensi	.00				
attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnand	у	IV	23d. Date of del Month	ivery Day Year
been signed by the should be detached	d by Ph	Part II. Other significant conditions con Status Post Trackers	1. 71 01	ulting in the underlying cause g	1 121 1	23e. Did tobacc		the cause of death
s beer 2 shou	plete	Dependence Status	Post Gostvosto	ony Take Pla	conent	24a. Was an autopsy	24b. Were au	utopsy findings avai completion of causi
ficete ha	e Completed by	25. Was case referred to medical	ditis with th	fre 1 Value Rep	26. Place of Death	performed	? death?	
is cert direct	To B	avaminar?	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ DOA	<b>+</b> - =		6 ☐ Other (Spe	cify)
After thi	lon: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury Wo	ıry at 28 ork? ] Yes 2 □ No	3d. Describe how in	njury occurred	
ifter death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Bf. Location (Street City or Town, St		ural Route Number.		
within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occurred at the tion and/or investigation, in my	time, date and place, ar opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
o the	Med	29b. Signature and title of certifier	and manner stated.	29c. Licer	se number	29d.	Date signed (Mont	h, Day, Year)
3 F 8		* Ligarald M	Thorn MI	P#1	5859	A	igust 8,	2006
X		30. Name and address of person who co Reginald M. B.			heat			
	48			" " " " " " " " " " " " " " " " " " "	1 1			

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			State of Maryland / Department of Health and Mental Hygiene Stete Registrar  State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 5 2 5 6 2 0
	Physici		1. Degedent's Name (First, Middle, Last)  HARRY FOWARD SPICER SR AUG 13 Day Bear 1201 AMM
	/Medic Examin	_	a. Facility Name (If not institution, give street and number)  7744 Glen Avenue  4b. City, Town, or Location of Death Pasadena  4c. County of Death Anne Arundel
	Funeral Director		7.44 G1EIT AVEITURE 6. Social Security Number 6. Sex 1 M 2 F 80 Yrs.  7. Age (In yrs. last birthday) 1 H Under 1 Year 1 H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 212-20-0118  9. Birthplace (State or Foreign Country) Months Days Hours Min.  1 M 2 F 80 Yrs.  1 M 2 F 80 Yrs.
	D		Jsual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	he Man 8a-f eh	Director	Maryland Anne Arundel Pasadena 1 □ Yes 2 ☒ No  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	with t	i Dir	106. Street and Number 7744 Glen Avenue 107. Zip Code 108. Citizen of What Country? USA
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show If Item 27 Is marked other than "natural", or Itema 24 or 28a-f show or other traumatic event, Ite Madical Evantral must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  14. Race - American Indian, Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  16. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, Specify Cuban, Mexican, Puerto Rican, etc.)
21215-0036	within 72 hou ene. than "natura ne Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  National  Cash Register
Maryland 2	12 should be filed within h and Mental Hygiene. 7 la marked other than " raumatic event, ILE Me.	To Be Co	17. Father's Name (First, Middle, Last) Harry Barker Spicer  18. Mother's Name (First, Middle, Maiden Sumame) Lillian Mae Finan
Mary	12 shou h and N 7 la mar raumat	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  7744 Glen Ave., Pasadena, Md. 21122
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 It any injury or other tra once.		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place)
Baltimore,	t. Pages rtment of rtant: If it rjury or o	,	1 □ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  Clen Haven Mem Pk   8/15/06   Glen Burnie, Maryland
Bal	permit. Departr Importa any inj		21. Signature of Funeral Service Licensee Kevin E Ecker  McCully-Polyniak Funeral Home, P.A.  22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A.  21.122
	Pnysician		23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death disease or condition
	/Medical Examiner		a.  Due to (or as a con a uence of):
	led sit	niner	Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury
8760,	icate be executed physician and s the burial-transit	dicai Examiner	that initiated events '
P.O. Box 68	aath certif attending for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	w requires that the de been signed by the should be detached	ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
Il Records,	The law ate has b page 2 sl	Completed	24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No
Vita	ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		27. Manner of Death 1
Divis	tal or Atte s after de al Directo ed in by th	Certification:	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	te Hospi 24 hour te Funer detely filt	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th withir To th	W	29b. Signature and vittle of certifier  29c. License number  29d. Date signed (Month, Day, Year)  Acy ut 1, 14, 2006
/	54		30. Name and address of person who completed cadse of death (Item 23a) (Type, Print)  Out vo (Senkunte Mel 406)
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 5 2006  32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Pari R. Sina 10, 2006 August 11:09 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 12700 Falls Road Cockeysville Baltimore County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 01, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2003F 75 Yrs. Hamadón, Iran Director 074-30-9726 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "naturel", or Items 23a or 28e-f show 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-f show other treumetic event, the Modical Exeminer must be notified at 1 Yes 2000 Director Maryland Baltimore County Cockeysville 10e. Street and Number 10g. Citizen of What Country? 12700 Falls Road 21030 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ģ Specify: Iranian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 04 Clothing Designer Garment Industry Pages 1 and 2 should be filed vent of Health and Mental Hygie out; if item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nosratola Ettehadieh Torran Rahimian ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree once. Bahram Sina, M.D. (Husband) 12700 Falls Road Cockeysville, Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Evans Funeral Chapel Aug. 11, 2006 Forest Hill, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium, Maryland 21093 me 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzeheimen **Physician** 4 TALS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Dualto for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by (070 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cancer Brekst 24a Was an has autopsy performed? certificate Division of Vital 1 Yes 2 No the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Hospital: ဂ္ဂ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ANatural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Wind Kluy D 31295 August 11, 2006 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Wendy Kloesz, M.D. 31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

6701 N. Charles Street Suite 4202 Baltimore, Maryland

			State of Maryland / Department of Health and Mental Hygiene  1 - For Registrar  Certificate of Death  Reg. No.  25622
	Physici: /Medic		1. Decedent's Name (First, Middle, Last)  ALICE  SCYVOO  2. Date of Death  Month  Day  Year  8:45 Am
	Examin Funeral		4a. Facility Name (If not institution, give street and number)  Brightview  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  1 M 2 F  8. Date of Birth (Month, Day, Year)  Country)  9. Birthplace (State or Foreign Country)
Ž.	Director		212-01-5103
2	the Maryl 28a-f eho	Funeral Director	MD Baltimore Baltimore  1 □ Yes 20 No  10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?
Ö	ath with 23a or ust be	ral Di	8100 Rossville Blvd. Apt 107 21236 USA
$\sim$	within 72 hours after death with the Maryland ane. then "naturel", or itema 23a or 28a-f show the Medical Examiner must be mollified at	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1
0 C	within 72 hc ene. then "natur	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  6  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  State of  Key Punch operator  Maryland
4 // (Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	6 Rey Functi Operator Maryland  17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)  Katherine Bradley
Mary	12 sho h and h is ma rauma	ľ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, I			Kenneth Ziegler- brother 1633 Thetford Rd. Baltimore, MD 21286  20a. Method of Disposition 1
Balti	permit. Departm Imports eny inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Evans Funeral Chapel  8800 Harford Rd. Parkville, MD21234
8760,	Proyected by Medical Examiner  (Medical Examiner transit the privile) transit the privile) transit transit the privile) transit transi	licai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
Division of Vital Records, P.O. Box 68	the Hospital or Attending Physician: The law requires that the death certifica hin 24 hours after death. The former of the strending phy the Funeral Director: After this certificate has been signed by the attending phy pietely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1
rds, P	quires that in signed b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Onknown
al Reco	: The law requir cate has been s , page 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
on of Vita	ding Physiclan: Th n. After this certificate funeral director, pag	ion: To Be	25. Was case referred to medical examiner?  1   Yes   2   No
Divisio	Hospital or Attsndi 24 hours after death. • Funeral Director: A etely filled in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)  28l. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the comple	×	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  8/10/206  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  8/10/206  8/10/206
	5 Sta	10	
	Regist		31. Date liled (Month, Day, Year)  AUG 1 5 2006  32. Fegistrar's Signature

		1	For State Registrer	State of M			t of Health and I e of Death		giene Reg. No.	2006	25623
	Physicia	an	1. Decedent's Name (First, Middle, Last	10. M.	Smit	h		2. Date of De	ath Day	2000	3. Time of Death 7.20 A M
	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give Scala Maris 5. Social Security Number 6. Se	HOSD	t CO ne (In yrs, last birth	4b. City,	Town, or Location of Death  A C N I U M  1 Year If Under 24 Hrs.  Days Hours Min.	8. Date of Bir (Month, Da	th		SCE Slace (State or Foreign stry)
	Director -f ahow	tor	Usual Residence of Decedent  10a. State  10b. County  HARGE	SED	10c. City, Town		A:		27		0d. Inside City Limits 1 ☐ Yes 2 ☐ No
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Heelth and Mental Hygiene. Itam 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be putilised at	by Funeral Director	10e. Street and Number  131 Line Sperior  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1   Yes 22 If Yes, Give Year or Dates:		13. Was Dece If Yes, spe	21014 dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	pecify Yes or No o Rican, etc.)	p- 1	Len of What Cour  US A  14. Race - Americ Black, White, Specify:	ean Indian,
21215-0036	filed within 72 hou Hygiene. Ither then "nature! ent, the Modice! E	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed) College (1-4or		Decedent's Usu (Give kind of wi life. DO NOT I	ork done during most of wo use retired)		a	nd of Business/In	dustry
Maryland	2 should be fill and Mental Hi Is marked oth raumatic avan	To Be	17. Father's Name (First, Middle, Last)  Morriso Mp F  19a. Informant's Name/Relationship (7)	ype, Print)	19b.	Mailing Addres	s (Street and Number or R	Q Q Jural Route Numb	SiR	osa	Code)
Baltimore, N	Page nent c ant: If ary or		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		cemeter	Disposition (Na v, crematory or	me of other place)  A O C C S - I S - I Address If Facility +	Date OLO	20c. L	cation - City or To	own, State
Bal	permit. Departit Importu		21. Signature of Funeral Service Licen  23a. Part 1. Enter the disease, or communication of the service of the	Zentota	od the death. Do n	EVANS	FUNELAL C	HAPEL - c or respiratory	BEL.	AIR, 3N	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disaase or condition resulting in death)	a. SEPSIS							
8760,	certificate be executed rding physicien and use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence (						
.O. Box 68	death certific e ettending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		e of pregnancy 2  Fetal death at time of death	3 □Ectopic 5 □ Other (s				23d. Date of deliv Month	rery Day Year
<u>α</u>	w requires that the de been signed by the e should be detached t	ρ	Part II. Other significant conditions of	ontributing to death	but not resulting in	the underlying	cause given in Part I.				the cause of death?
Division of Vital Records,	The law ate hes b page 2 s	Completed						per 1□ Yes	opsy formed? 2 <b>X</b> No	prior to co	opsy findings available ompletion of cause of
Vitt	Physician: rthis certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1  Inpa	tient 2□ER/Ou	tpatient 3 🗆 [	Others	ath <i>Check on</i> Home 5 ☐ Re		6 <b>X</b> Other (Spec	ty) HOSPICE
sion of	ding P. After fune	Certification: T	27. Manner of Death  1. Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	e Zeo Place of I		rime of njury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe			ral Route Number,
Divi	To the Hospitel or Atten within 24 hours after deat within 24 hours after deat To the Funerel Directors completely filled in by the	al Certif	4 Homicide determined	building,	njury - At home, fa etc. (Specify) st of my knowledge	e, death occurre	d at the time, date and place	City or T	own, State	e) and manner as	stated.
	To the Hos within 24 h To the Ful completely	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier	niner: On the basis and manner	of examination an	2	on, in my opinion, death occurrence of the second occurrence of the second occurrence of the second occurrence of the second occurrence of the second occurrence of the second occurrence of the second occurrence occurrenc		29d. Da	te signed (Month	, Day, Year)
	Si	ate	30. Name and address of person who  DR. TARIO MAHMOO  31. Date filed (Month, Day, Year)	D 2300 D	f death (Item 23a) <b>ULANEY V</b> strar's Signature	(Type, Print)					

DHMH 17 Rev 1/2001

AUGUST 14, 2006 7:20 a.m.

JOSEPHINE SMITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25624 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3:10 AM **Physician** 2006 Robert Eugene Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Gounty of Death Examiner eda guare Oita 0 lanhlin mol If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours XIXM 2□F 216-34-5218 June 25, 1936 Director 70 Pennsylvania Usual Residence of Deceden 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State or Itams 23a or 28a-f show on refinest be notified at 1 ☐ Yes 🍇 No Completed by Funeral Director Maryland | Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1118 Stephen Drive 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 XXes 2 □ No If Yes, Give 1 Never Married 2XXMarried ō 1 ☐ Yes 2 ☑ ※ 0 Specify: Specify: lf Yes, Give Year or Dates: traumetic evant, the Medical Exar White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry rthan Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Salesman Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Walter Smith Clara May Hetterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 1118 Stephen Drive, Baltimore, Maryland 21220 Brenda Smith (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any injury or o once. tagurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard. Aug. 13, 2006 Baltimore, Maryland Formal Pervice Licenses 22. Name and Address of Facility
Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancer 0/0n ( /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): -burial-68760. that the death certificate be Physician/Medical the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 1 Yes 2 No 2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🗋 Nursing Home 5 🗋 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 X Natural 5 Pending investigation 1 🗌 Yes 2 No death. 2 🗋 Accident Diractor: 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide 24 hours a A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier completely (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier 29c. License number

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 5 20 06

31. Date filed (Month, Day, Year)

Rahama 9000 F

Belle

06-06019 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Horace Saunders 1- For State Certificate of Death Reg No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 13, 2006 1614 hrs orace **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death NIA University Hospital Baltimore If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs last birthday) **Funeral** Foreign Country) 12-24-1953 Months Days Hours Director 214-62-7255 1 V M Usual Residence of Decedent any Yes 2 No or items 23a or 28a-f show must be notified at once. MO hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? Funeral Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes 1 Yes 2 No specify 4 Divorced If Yes, Give Year 3 Widowed Examiner ≥ 16a Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene 27 is marked other than " Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 15/12abeth Horace Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1759 Grandeview Are Severn, md. 21144 ဥ 19a. Informant's Name/Relationship (Type, Print) Certchember Shelia t of Health and: If item 27 is 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Owing miles inD Varrison forest vet Donation 5 Other Specify: ignature of Funeral Ser ice Lic 22. Name and Address of Facility 3405 w. alide Complications that caused the death. Do not enter the mo of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Approximate Interval Physician the disease, o failure. List only one cause on each line. Between Onset and /Medical Death Immediate C use (Final disease Arteriosclerotic Cardiovascular Disease а Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical **X**UNPENDED AMENDED attending physician for use as the burial 23a,pt.11,27 per me g858 8-28-06 vt Division of Vital Records, P.O. Box 68760. 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No 2 No 1 Yes To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28b. Time of Injury Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending within 24 hours after death To the Funeral Director: Accident 28e. Place of Injury - At home, farm, street, factory office building, etc. 28f Location (Street and Number or Rural Route Number, City 3 \_ 6 Could not be Suicide or Town, State) determined 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. August 14, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. <sup>ea</sup>5 2006 State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1.3 per doc. 10b.c.e.19b per inf 9859 9-21-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Deanna P. Skaggs 2. Date of Death 3. **12.23**ф 12.35 Рм 1. Decedent's Name (First, Middle, Last) Month **Physician** 6 10 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Country Howard Howard Hospitz, Culumble If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2 € Months 230-58-4350 Yrs. march 18, 1944 Director Virginia Usual Residence of Decedent with the Maryland Severn 10d. Inside City Limits A.A. 10a. State 10b. County 10c. City, Town or Location or than "netural, or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director a olum 10g. Citizen of What Country? 10e. Street and Number Cuire 10f. Zip Code 908 1144 death v 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. other than "netural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No ac Baltimore, Maryland 21215-0036 Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MILITARU College (1-4or 5+) Elementary/Secondary (0-12) STORE lothing 12th presenta permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie important: If item 27 is marked other tt any injury or other traumatic event, IIIA 900.8. <e 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathers-Name (First, Middle, Last) Ochaldine Hudgins earl miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 husband 1908 Sever, md. Flenoria S Kaggs 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, grematory or other place. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8 -15-04 Vet. Cem rownsrille 4 ☐ Donation /5 ☐ Other (Specify) 22. Name and Address of Facility 270 Fred HILTOS 21. Signature of Pineral Service Licensee P. march Funeral Home Bacts, and, 21229 23a. Part. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease a condition resulting in death) Cardiac Hrrast Physician /Medical Due to (or as a consequence of): Examiner my o Condicul Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) rthis certificate has been signed by the rai director, page 2 should be detached 9☐ Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes or Attending Physicien: Director: After this certific I in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 2 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or Att within 24 hours after d To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8-10-06 Dous 3709 Cajn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIE Burvie Fox lane CHAWLA KA MD 20715 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** August 9, 2006 Mary Catherine Spangenberg 2025 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery County General Hospital Olney Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 250F 220-01-3763 Director 86 April 2,1920 | Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State 28a-f show the Medical Examiner must be notified at Clarksville 1 ☐ Yes 🎾 ☐ No Howard Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 13351 Triadelphia Mill Road 21029 USA 238 Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Items filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maryland Unknown Information Clerk Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be fill pertment of Health and Mental Hoortant: If Item 27 is marked off y injury or other traumatic even Be Samuel Cornwell ္ Kate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Gregory Spangenberg 3235 Roselie Road, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 8/14/2006 4 ☐ Donation 5 ☐ Other (Specify) Fullerton, Maryland Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road Baltimore, Maryland permit.
Deportrimporta 21. Signature of Funeral Service Licenses ulson 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cirrhosis of the liver 10 Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Hepatitis C 10 Years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Transfusion 1996 attending physicien and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) signed by the at id be detached fo 1 ☐ Yes 2 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 → No 1 ☐ Yes 217 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3416 OLAMBILOON COURT, SUITE LON, Whyn JACIESON, im 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Year August Physician 6:18 PM Gary Samuel Styles 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y. Sept. 7, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) **Funeral** 1⊠M 2□F 48 Maryland 220 76 6728 1957 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County e filed within 72 hours after deeth with the Marylan al tygiene i other then "nature!", or fleme 23s or 28s-f show tother then "nature!", or fleme 23s or 28s-f show vent, the Mackins Exeminer mant he notified at 1 X Yes 2 □ No Maryland Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 21211 3542 Ash Street Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 A Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Construction 12th 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental Hism 27 Is marked ott Eileen G. Lowery James H. Styles, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 Is any injury or other treugonce. Westminster, Maryland 21158 Cheryl Young / sister 1502 Chris Lane 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Holy Cross Cemetery 8/14/2006 4 □ Donationy 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatu 4 Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Amhymmia urdiac **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner been signed by the attending physicien and should be detached for use as the burial-transit Micohol unknown that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 Yes 2 No certificate or Attending Physician: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 5 2006

Application Union

Memorial Hospital

		•	For State Registrar	State of Man	-	epartment Certificate			, ,	iene •g. No. 200	16	25529
	Physicia	an	Decedent's Name (First, Middle, L.	Edwin	Singh				2. Date of Deat Month	Day Y	ear	. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g.		Ding.		Town, or	Location of Deat	August	10 200 4c. County of		:00 A. M
			213 Grove Park					nore		Anne		
	Funeral Director		213 15 9246	Sex 7. Age (III 1 M 2 □ F 69	In yrs. last birth	rs. If Under	Days	Hours Min.	8. Date of Birth (Month, Day, Aug • 17	, Year) 936	Birthplace Country)	(State or Foreign ia
-	ow II		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, Town	or Localion					10d. I	Inside City Limits
	e Man la-fah	ctor	Maryland Anne A	rundel	Balt	imore					1	1 ☐ Yes 2 ☐ No
	h with th	al Directo	10e. Street and Number 213 Grove Par	k Road		10f. Zip (	Code 212	225	1	0g. Citizen of Wha	at Country?	
UU36	72 hours after death with the Maryland "natural", or flema 23a or 28a-f ahow idical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Decedenl Eve Armed Forces? 1 Tyes 2 P No If Yes, Give Year or Dates:	er in U.S.	13. Was Decede If Yes, speci		ispanic Origin? (S in, Mexican, Puerl Specify:	Specify Yes or No- to Rican, etc.)		American Ir White, elc. Indiai	
215-0036	. 22	Be Completed	15. Decedent's (Specify only highest g	Education rade completed)  Coflege (1-4or 5+)		Decedent's Usual 'Give kind of work life. DO NOT use	k done d e retired	during most of wo. f)	rking	16b. Kind of Busin		,
	a filed within Il Hygiene. other then	Com		5+ years	Co	orrection	nal			Jessup C	orrec	tional
Maryland 2	B d la b y	To Be	17. Father's Name (First, Middle, Las Emma	nuel Singh					me (First, Middle, I ey Lal	Maiden Sumame)		
	12 short and 7 is m		19a. Informant's Name/Relationship Sarika Singh /			Mailing Address  B Grove			ural Route Number Baltimor	city or Town, Sta		
Baltimore,	of He		20a. Method of Disposition  1 A Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State	cemetery	Disposition (Nam , crematory or oti aven Men	her plac	ark   8/12		20c. Location - Cit Glen Buri		
Balt	permit. Page Depertment Important: If any Injury o		21. Signature of Funeral Service Lic	ensee	h.				Gonce Funday Balt			
	licate be executed  Medical Examiner  Styles purial-transit  The p	edicai Examîner	23a. Part1. Enter the disease or co- shock, or heart failure. List on Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	consequence of	(i):	) L c	y, such as cardia	Co	2.00	Inte	proximate erval Between set and Death
P.O. Box 6	ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at tim	Fetal death	3 ☐Ectopic pre 5 ☐ Other (spe				23d. Date o Month	f delivery Day	/ Year
	uires that the de	by	Part II. Other significant conditions	contributing to death but n	not resulting in	the underlying ca	use give	en in Part I.	23e. Did tot	pacco use contribu		ause of death?
Vital Records,	ne law require hes been sla ge 2 should t	Completed							24a. Was a autops perforr	n 24b. Wer	r to comple	findings available
ā		0	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes wath (Check only on	1 D	Yes 2□	No
	ding Physician: The lav h. After this certificete hes funeral director, page 2	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient				er: 4 🗆 Nursing H		ence 6 Other (	Specify)	
Division of	Attending Physician: It death. actor: After this certifict by the funeral director,	atlon:	27. Manner of Death Natural 5 Pending 2 Accident investigati		'ear) 28b. Ti	me of 28 jury M	Bc. Injun Work	yat k? Yes 2∐No	28d. Describe ho	ow injury occurred		
DIVIS	al or Attand s after death ii Diractor: ,	Certification:	3 ☐ Suicide 6 ☐ Could not determine		Al home, fari (Specify)	n, street, factory,	, office		28f. Location (St. City or Town	reet and Number on, State)	or Rural Ro	ute Number,
	To the Hospitel or At within 24 hours after of To the Funeral Dirac completely filled in by	edical	29a. Certifier Certifying I (Check only one)	Physician: To the best of naminer: On the basis of ex and manner stated	kamination and	death occurred a /or investigation,	at the tin	ne, date and place pinion, death occu	a, and due to the caurred at the time, de	ause(s) and manne ate and place, and	er as stated due to the	l. cause(s)
	To the To the Comp	×	29b. Signature and title of certifier	thN		7 W 29c.	License	D39	149 9	9d. Date signed (A	Aonth, Day,	Year) N Zool
	0)		30 Name and address of person wh	completed cause of deat	th (Item 23a) (1	Type, Print)	30	01,5	Heren Trem	ONA	Sh	122 -
3	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 5 2	3 Abgistrar's	Signature	harle						1)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August **Physician** Ruth I. Shipley 9:15 A. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Mariner Health of North Arundel 8. Date of Birth (Month, Day, Year) Aug. 23, 1910 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 95 Months Days Hours 1 M 2 X F Pennsylvania Director 194 09 5846 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28e-f show with Injury or other traumatic event, Ita Macified Examinational Be natified at once. 1 Yes 2 No Glen Burnie Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21061 313 Hospital Drive Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Grocery Store 12th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Bessie I. Lutes Benjamin F. Lewis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Vehlow 500 Forest View Road Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Crownsville, Maryland MD State Veteran Cem. 8/18/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** annel luce disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit ed by the attending physicien and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate hes been signed page 2 should be 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Certification; To 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pendina efter death.

Director: Aft
in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours e To the Funeral D 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 208 31. Date flied (Month, Day, Year, 32 Registrar's Signature State 5 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	aryland		artment of rtificate o		and Me		giene Reg. No.	006	25631
	ž		Decedent's Name (First, Middle,						2	. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		HARRY R	SWE/	V50	10				Aug	3	2006	8100 AM
	Examin		4a. Facility Name (If not institution,				4b. City, Town	, or Location of	of Death	d	4c. C	County of Death	
		Marie I		nritan Ho	e (In yrs. la	at histhday	If Under 1 Ye	ar If Under		Date of Birth	h	9 Right	place (State or Foreign
	Funeral			10XM 2□ F		Yrs.	Months Day		Min.	Date of Birth (Month, Day 5-10-	1 9 2 5	5 Coul	ntry)
	Director	-	5 5 9 - 2 6 - 5 0 4 6 Usual Residence of Decedent	3	3 1								
	yland how		10a. State 10b. County		10c. City,	, Town or Lo	ocation						10d. Inside City Limits
	a-fs	ctor	MD Baltim	ore	Ba1	timo	re						
	ith th	Funeral Director	10e. Street and Number				10f. Zip Cod	9			10g. Citizo	en of What Cou	ntry?
	ath w	rai	622 Carrollwo			A 12	21220		nin? (Cnaci		USA	4. Race - Ameri	can Indian
	er de Itam	nue	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Armed Forces? d 1 Tes 2 Tes	No		Was Decedent of If Yes, specify C		n, Puerto Ri	can, etc.)		Black, White,	etc.
36	II', or	by F	Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII		1□Yes 2₺	No Specify:			5	Specify: Wh:	ite
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-f show ta Nadical Exertinal tre notified at	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Oc	cupation	et of working		16b. Kin	d of Business/Ir	dustry
218	thin 7 e.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use re	rired)			ъ.		
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pu	tal H d off	Be	17. Father's Name (First, Middle, L.	,						First, Middle,			
2	12 should be filed within " h and Mental Hygiene. 7 is marked other than " fraumatic avant, the Med	ဥ	Harry Rudolp  19a. Informant's Name/Relationshi			19h Maili	ing Address (Str	Nor	ma G eror <i>Bural</i> I	eorgi Boute Numbe	na A	nderso	On Code)
Maryland	d 2 si th an t7 is r traur		Georgina Coff			1	-						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f ahow ampingury or other traumatic avant. Its Medical Eval., its must be rediffed at Ance.		20a. Method of Disposition		20b. PI		osition (Name of matory or other		Da			ation - City or T	
JO T	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State ecify)	1	*	v Crema	1	8-4-	06	Ral	timore	MD
Baltimore,	mit. I partm porta / inju		21. Signature of Funeral Service L		, Du	2	2. Name and Ad	dress of Facili	Brad	lev-A	shto	n Fune	ral Home
m	Depa Impo any ir		* Dithally			P A	1, 2134	Will Will	ow S	pring	Roa	d, 212	222
*			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each l	d the death line.	. Do not en	iter the mode of	dying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
*33:	Physician		Immediate Cause (Final disease or condition	a M	400	ard	n/ -	In to	rcy	_			1 wK
	/Medical Examiner		resulting in death)	Due to (or as	consequ	uence of):							
*	_xammo	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequ	uence of):		····					
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ν,	sician and burial-transit	Examiner	resulting in death) Last	Due to (or as	s a consequ	uence of):	· · · · · · · · · · · · · · · · · · ·						
160	ate be ex nysician he burial	cal		d									
89	ng ph as th		IF FEMALE:										
Box	death certifica e attending ph id for use as ti	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal	death 3	□Ectopic pregna				2:	3d. Date of delive	ery Day Year
		Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of de	eath 5	Other (specify	)					,
P.0	ac ac		Part II. Dther significant condition	s contributing to death	but not resu	ulting in the	underlying cause	given in Part I	ı.	23e. Did t	obacco us	se contribute to	the cause of death?
ds,	signed b	d by	COPP							10	Yes 2	No 3 Pro	bably 4 \( Unknown
cor	w require been si should I	Completed								24a. Was	an	24b. Were aut	opsy findings available
Re	The lav	m o								autor perfo	osy ormed? 2 No	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause of
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Į V	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Ninpat	tient 2 🗆	ER/Outpatie	ent 3 DOA	Other: 4 N	ursing Hom	e 5 🗆 Resid	dence 6	☐Other (Spec	ify)
u o	Attanding Physician: ir death. actor: After this certifica		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury ay Year)	28b. Time Injury		njury at Work?		3d. Describe I	how injury	occurred /	
sio	Attandi death. ctor: A y the fu	catl	2 Accident investig	ot be				1 Yes 2		of Location (	Ctenat and	d Number of Pu	ral Route Number,
Division of Vital Records,	or Atter of Dirac	Certification:	4 Homicide determi		etc. (Specify		treet, factory, off	ice	-	City or To	wn, State)	i vallibor or rigi	arriodio rombor,
-	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fo		29a, Certifier Certifying	Physicien: To the bes	t of my kno	wledge, dea	ith occurred at th	e time, date a	nd place, ar	nd due to the	cause(s)	and manner as	stated.
	a Hos 24 h a Fur letely	Medical		xeminer: On the basis and manner s	of examinal								
	To th within To th comp	Me	29b. Signature and little of certifier	1		y i		ense number	_			e signed (Month	
			1 Helfert	Jun		1	D	005	373	22	144	19 31	2006
(1	XI		30. Name and address of person	who completed cause of	death (Item	23a) (Type	p, Print)	005. B1	171	MARI	=		
7	)			1MARITA	trar's Signa	HOS	P	05/1	61/1	701(2			
	St Regist	ate trar	31. Date filed (Month, Day, Year)  AUG 1 5		urai s digria	D AND	9 - 10 -						
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 9,2006 3:40 a<sup>M</sup> ANTONIA SCHMIHULEC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 16,1921 ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL GLEN BURNIE ff Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 X F 84 ÜKRAINE 216-32-9252 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Expressiver must be notified at 1 Yes 2 No Director MD. ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ŏ 1205 VILLA ISLE COURT 21122 or Items 23s U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene important: if Itam 27 is marked other than "natural; or Item eny injury or other traumatic event, the Medical Experimentance. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) DOMESTIC MD. NATIONAL BANK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) NINA N/A IVAN IVANOVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE O'NEILL/DAUGHTER 8593 MORVEN ROAD, PARKVILLE, MARYLAND 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MICHAEL'S UKRAINIAN 8/11/06 BALTIMORE, MD. 21. Signature of Funda Privice Licensee TTLLY AGESTERN INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of): Examiner espivat OVY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital 29a. Certifier 1 [Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Hospital 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 5 2006 Registrar

		•	For State Registrar	State of Man		epartment of H Certificate of L			ene 2 0 0 6	25633
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)	Examin		4a. Facility Name (If not institution, give	street and number)	CINITE	4b. City, Town, or	Location of Death		4c. County of Dea	111006-
	Funeral		5. Social Security Number 6. Se	7. Age (I	n yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Director		212-12-1013	□M 21X F	86 Y	s. Months Days	Hours Min.	05708719	20	PA PA
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
	Mary I eho	ţō	MD BALT	IMORE	В	ALTIMORE				1 ☐ Yes 2 💢 No
	or 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
	23a		1500 BEDFORD AV				21208	- * * 1	14 Dans Am	USA
920	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel', or iteme 23a or 28a-f ehow important: If item 27 is marked other then "naturel', or iteme 23a or 28a-f ehow appringuy or other traumatic event, the Medical Examinal must be notified at ance.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of Hi If Yes, specity Cuba 1 ☐ Yes 2 ☒ No	Specify:	Rican, etc.)	14. Race - Ame Black, Whi	
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			- For Amend #18 Per	FH G858 8/15	706 <b>C</b>	rtificate of	Death	Re  2. Date of Death		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death	TOUN	4c. County of Death	TIMODE
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9036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural" or items 23a or 28e-1 show or other treumatic event, it a Medical Exaction or not be rediffed at	by Funeral	11. Marital Status 12 1 Never Married 2 Marned 3 X Widowed 4 Divorced	. Was Decedent Ever in U.S Amed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
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Baltimore,	permit. Pages 1 am Depertment of Heali Important: If item 2 sny injury or other ance.		20a. Method of Disposition  1	noval from State	emetery, cre	osition (Name of matory or other place OUNG MEN*			WOODLAWN	
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DHMH 17 Rev 1/2001

			For State Registrar	State of Man	•	epartme C <i>ertifica</i>				giene Reg. No.	2006	25635
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of kno	2 should and Men is marke sumatic	2	19a. Informant's Name/Relationship (Typ HELEN HOLLANDER /		19b. l	Mailing Addre	ss (Street an	d Number or Rui	al Route Numb	er, City or 1 RΔI T I	Town, State, Zip	
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father Baltimore,	permit. Pag Department Important: any injury once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		ANSIL I		and Address	1	L LEVIN			
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Div	To the Hospital or Attending Physician: The within 24 hours eller death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page		4 Homicide determined	building, etc.	(Specify)		••		City or To	wn, State)		
	n 24 ho he Fun detely f	Medical	29a. Certifier 1 Certifying Physics (Check only one)	er: On the basis of e and manner state	examination and	or investigati	on, in my opir	nion, death occu	red at the time,	date and p	place, and due to	o the cause(s)
	To t To t	2	29b. Signature and title of certifier	ınbau	mM		RE.	S-00	00	Aug	signed (Month,	Dey, Year) 12, 2006
	10		30. Name and address of person who cou	npleted cause of dea	ath (Item 23a) (	Type, Print)	nai	Hospit	alof	Ba	Utim	ore
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	Signature	mall I						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10, Dorothy C. Valancius August 2006 11:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1106 Orems Road Middle River Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖸 F 219-16-8252 82 Director April 4\_ 1924 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 289-f show item 27 is marked other then "natural", or itema 23e or 28e-f ebov other treumatic event, the Modical Exacts ar mark the rediffied at 1 □ Yes 2 No Maryland Baltimore Middle River Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 end 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Items 23e or? 1106 Orems Road 21220 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 êby ⊁ 1 Yes 2000 Specify: 3XDWidowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Michael Krisman Catherine Lukaszewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Valancius (Son) 1106 Orems Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its eny injury or ot XXBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. Aug. 15, 2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee any ir <u> 1407 Old Eastern Avenue, Essex, Maryland 21221</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fige. Approximate Interval Between Onset and Death Immediate Cause (Final disease of distinguished) **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attanding Physicien: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence ol) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Day Year Month 4 ☐ Pregnant at time of death 5 Other (specify) P E deteched 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient ၉ 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation s after death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a peili 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical completely within 2 To the 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9110PHILADELPHIA TIR. 03 En 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

5 2006

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month 11.05 PM **Physician** LILLIE MAE WILLIAMS AUGUST 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GIEN BURNIE ANNE ARUNDEL BALTIMOTE WARHINGTON MEDICAL CENTE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** 1 M 2X F 217-34-5458 68 Jan 14, 1938 Ohio Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other than "natural", or iteme 23a or 28a-1 ebov traumatic event, the Medical Examinar must be indiffied at 1 ☐ Yes 2 No Rosedale Maryland Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 6727 Fordcrest Road USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Baltimore, Maryland 21215-0036 Specify. 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator A T & T Unknown Unknown th and Mental Hygis and 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sargent Agnes Fletcher Vernon ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a Item 27 I other tra 6727 Fordcrest Rd., Rosedale, Md. 21237 (Daughter) Joyce Frock 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or ot ance. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Cedar Hill Cemetery 8/14/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 237 E Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STEM ARUDENT EZEBRO VASCULAR **Physician** BRAIN /Medical Due to (or as a consequence of) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes certificate 2 No 1 ☐ Yes or Attending Physician: After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 🖰 No ٩ 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A l Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Date signed (Month, Day, Year) 29b. Signature and Mile of certifier 545149 W)

State Registrar 31. Date filed (Month, Day,

Glen Burnie.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 3:35р м Dorothy J. Woods August 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 11 Debkay Court Baltimore Essex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May24, 1945 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 262-72-4023 61 Yrs MAryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County r than "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Debkay Court 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 Never Married 20 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 10th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental I permit. Pages 1 and 2 should be Department of Heath and Mental Important: If tem 27 is marked any liquy or other traumatic evone. William Hawkins Is marked Gladys Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin H. Woods/husband 11 Debkay Court Baltimore MD 21221 Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 8/14/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave.Balto.MD Connelly Funeral Home of Essex 21221 23a. Part. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUDCARDIA /Medical Due to (or as a consequence of) Examiner OCONACO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of physician and s the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence ol): Box 68760, by Physician/Medical signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 SNo
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) O 9 Unknown ۵ The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause ol death? certificate as the lirector, page 2 s 2 No 1 Yes of Vital Attending Physician: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□Yes 2No this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Jeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural
2 Accident 5 Pendina nours after death.

neral Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours a

To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23465 8/12/06 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Glen Burnie, MD 21061 7845 OAKWOOL meses WD 31. Date liled (Month, Day, 32. Registrar's Signature Year) State 2006 SA SHELL Registrar

		-	State of Maryland / Depa	rtment of Health and Mitificate of Death		ene g. No. 2006	25639	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Julia Hill Wright		2. Date of Death Month August 10		3. Time of Death 2:20pm M	
	/Medic Examin	_	4a. Fecility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton		4c. County of Dea		
Í	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 90 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Sept. 15	9. Bi ,1915 La	nthplace (State or Foreign country)	
	Maryland -f ahow	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lot  MD Prince Georges Temp1	e Hills			10d. Inside City Limits 1 Ø✓es 2 □ No	
	with the	Direc	10e. Street and Number 3803 28th Avenue	10f. Zip Code 02748	10	g. Citizen of What C	Country?	
36	urs after death al', or itams 23 Examiner mus	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ⅓ No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto f ☐ Yes 25 (No Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
21215-0036	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, the Medical Examiner must be notified at	Completed by	(Specify only highest grade completed) (Give life, L	ent's Usual Occupation kind of work done during most of workin O NOT use retired) memaker	ng	6b. Kind of Busines.  Own Home	s/Industry	
land	uid be filed fental Hyg rked other itc avant,	To Be C	17. Father's Name (First, Middle, Last) Soloman Isaac Hill	18. Mother's Name Bessie		laiden Sumame)		
Maryland	nd 2 shou aith and M 27 is mai r traumai			g Address (Street and Number or Rura 3 28th Ave. Temple			Zip Code)	
Baltimore,	permit. Pages 1 and Department of Healt Important: if item 2 any injury or other once.		4 Donation 5 Other (Specify) Salisbury	National Cemetery 2	st 16, 2006	Oc. Location - City of Salisbury, N		
Bai	Departiment in port			Name and Address of Facility Charles L. Stevens Fu 1501 Fast Fort Ave. B				
8760,	kaminer physician and physician and physician and physician step buriar-transit	al Examiner	Ical Examiner	23a. Part. Enter the disease or complications that cause the death. Do not interest the disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Thrive	respiratory arre	St.	Approximate interval Between Onset Air Death
Box 6	ath certif attending for use as	Physician/Medic		Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year	
rds, P.O.	quires that the de n signed by the e uld be detached i	ρ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tob		to the cause of death?  Probably 4 □Unknown	
Il Records,	The law requires that set has been signed by page 2 should be detailed.	Completed		27.2	24a. Was an autopsy perform	prior to death?	autopsy findings available o completion of cause of essential No	
Vital	Physician: 1 this certifice ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 (\$ No Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatien	26. Place of Death	West of the second	nce 6 □Other (Sp	naci6i)	
o	After Fune	<del> -</del>	27. Mann r of Death  1 YNatural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injury			w injury occurred	octiy)	
Division	al or Attendi s after death. if Diractor: A id in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town	reet and Number or i , State)	Rural Route Number,	
	To the Hospital or / within 24 hours after To the Funeral Direct completely filled in D	Medical C	29a. Certifier (Check only one)  1 Cartifying Physician: To the basis of my knowledge death one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.					
	To th within To th	W	29b. Signature and title of certifier	29c. License number 5 3	5	OB 11		
			30. Name and address of person who completed cause of death (Item 23a) (Type, 2503 Succentry U.D., C.)	Print)	207			
-	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 1 5 2006  AUG 1 5 2006	<i>U</i>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 1220 fM 27 2006 Charles Anthony Walker 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARVINO EL CENTER-WHEY LAND ANNE ARVIDER MEICAL ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ₹M 2 □ F Vrs 30,1919 Washington D.C 86 579-10-9069 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Annapolis 10f, Zip Code 10g, Citizen of What Country? 10e, Street and Number 21401 United States 2543 Mission Hills Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No 1948− If Yes, Give Year or Dates: 1979 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Tabler Charles Joseph Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Regina Walker / Wife 2543 Mission Hills Court Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2006 New Cathedral Cem. Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Servide Licensee 1 leci 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lines. Immediate Cause (Final Muntonia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) itions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 3 No 1 🗌 Yes 215 No 1 🗌 Yes 26. 3 DOA Dther: 4

Physician /Medical Examiner Examine

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

Be

2

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Modical Exeminer must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic evant, the Madical Exemples.

Baltimore, Maryland 21215-0036

the Maryland

death with

burial-transit attending physicien as the esn 5 detached pe hes To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica filled in by the funeral

ician/Medical

Physi

þ

Completed

Be

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Certification:

Medical

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

F F8	EMALE:	
23b.	Was deced	dent pregnant
		12 months?
	1 Tyes	2 🗆 No
	9 Unkno	wn

dit ii. o ii.o.	0.3	 ing to down but	cooning	ino andonying ou	ado garan an a da	

i. Was case referred to medical		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: Inpatient 2 .	ER/Outpatient
. Manner of Death		28b. Time of Injury

Place of Dea	ath (Ci	heck only one)	
☐ Nursing H	lome	5 Residence	6 ☐Other (Specify)
	28d.	Describe how in:	ury occurred

27. Manner of Death 1 ♣ Natural 2 ☐ Accident	5 Pending	28a. Date of (Month
3 Suicide 4 Homicide	6 Could not be determined	28e. Place o

Time of Injury	М	28c. Injury at Work?	2 DNs	28d. Describe how injury occurred
	IVI	1 🗆 Yes	2 1140	

28e.	Place of In building, e	njury - At home, f etc. (Specify)	arm, street, facto	ory, office	

10	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

	one)				
29b.	Signature	and	title	of	certifier

29a. Certifier

(Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

_	1	A	ged.		-	M.D.			
me	and	addres	s of p	erson wh	no com	oleted cause	e of death (Item ALレベラデュ	1 23a) (Type, Prii かる)にんし	nt) Ce

and manner stated

29c. License number D005665B

29d. Date signed (Month, Day, Year) July 27, 2006

So. Harris aris	addition of person
TiTUS	ARRAHAM
	(Month, Day, Year)

CENTER

2001 medical Parturbes ANNAPOLIS, MD

State Registrar

DHMH 17 Rev 1/2001

AUG 1 5 2006



		For State	State of Ma		epartment ( <i>Certificate</i>	of Death	Mental H	_	2006	2564
		Registrar  1. Decedent's Name (First, Middle, Lo	ast)		Cortinoato	or Bouirr	2. Date of D			3. Time of Death
Physicia /Medic		Kay A. Windsor					Augus	t 11	2006	8:13 p <sup>M</sup>
Examine		4a. Facility Name (If not institution, gi GREATER BALTIM		I. CENTER		wn, or Location of Deal	th		county of Death LTIMORE	
Funeral				e (In yrs. last birt	hday) If Under 1	Year   ff Under 24 Hrs	8. Date of B			place (State or Foreign
Director		217-36-3018	1 ☐ M 2 🕮 F	66	Yrs. Months [	Days Hours Min	8. Date of B (Month, 2 2/29/	1940		nsylvania
and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
Maryi -f ehc	ģ	MD Balti	more	Bal	timore					1 ☐ Yes 2 <b>X</b> No
th the or 28a	Director	10e. Street and Number			10f. Zip C	ode		10g. Citize	en of What Cour	ntry?
ath wi	rai	3713 Red Ber				1236			JSA	
ter de	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent £ Armed Forces? 1 ☐ Yes 2 ₹ □ ■		13. Was Deceder If Yes, specify	t of Hispanic Origin? (\$ Cuban, Mexican, Puer	Specify Yes or N to Rican, etc.)	10-	<ol> <li>Race - Americ Black, White,</li> </ol>	
1215-0036 within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f ehow the Madical Examiner must be notified at	۾	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes <b>X</b> C	XNo Specify:		S	Specify: 7	white
72 ho	Completed	15. Decedent's E (Specify only highest g	iducation rade completed)	16a.	Decedent's Usual ( (Give kind of work	Occupation done during most of wo	rking		of Business/In	
within within them	dmo	Elementary/Secondary (0-12)	College (1-4or 5	4		of police			iltinko	
TA TA 212 at 1 Hygiene. Went, the we	Be C	17. Father's Name (First, Middle, Las	t)		0112.02		me (First, Middl	e, Maiden S	umame)	
arylan should be should be marked o	일	KUSSELL	AUMAN			KA	THRYI	V_ /	KAMF	)
01 (0 - 0		19a. Informant's Name/Relationship		(1)	Mailing Address (S	treet and Number or R	$\circ$		4.8	
ore, M	d	CONNIE LAME  20a. Method of Disposition	RIGHT-NE	20b. Place of	Disposition (Name	of	Date	PRKU 20c. Loca	ation - City or To	Wn, State
Baltimore, semil. Pages 1 at appraisant of the monographic of the mono		1. Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Spec		W COUNTER	y, crematory or other	PARK 16	2006	Par	RKVILLE	in D
Baltimol Bearin: Pages Department of Important: If i		21. Signature of Funeral Service Lice				Address of Facility	4000	- 1111	2800 i-	IARFORD RO
0 8988		16/st O. L	>41.		EVANS	FUNERA			PARKU	illE, MD 2189
		23a. Pa/11. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lin	the death. Do n	ot enter the mode o	of dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	ry Embo						
Examiner			Lung Ca		n).					
ב פ	ner	Sequentially fist conditions, If any, reading to intrinculate cause. Enter Underlying Cause (Disease or injury	D	в вольафиентее с	M):					
ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as:	a consequence o	wf)-					
68760, tificate be executed g physicien and as the burial-transit	a		20010 (01231	a consequence c	<i>,</i> , , , , , , , , , , , , , , , , , ,				İ	
687 tiflicate g phys	ledical		<u> </u>							
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed refeath.  etter: After this certificate has been signed by the ettending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy 2  Fetal death	3 ☐ Ectopic preg	nancy		23	d. Date of delive	•
P.O. BOX that the death cered by the ettendir detached for use	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 Other (speci	fy)			Month	Day Year
that the opposite of the physical contracts	P.	Part II. Other significent conditions	contributing to death bu	ut not resulting in	the underlying cau	se given in Part I.	23e. Did	tobacco use	e contribute to the	he cause of death?
rds quires an sign	ed b						10	Yes 2	No 3 ☐ Prob	pably 45 Unknown
eco law re as bec	piet						24a. Wa	s an	24b. Were auto	psy findings available mpletion of cause of
The	Completed						per	ormed? 2 1 No	death? 1 ☐ Yes	
Vita iician certifii	Be	25. Was case referred to medical examiner?	Hospital:			Othor	ath (Check only			
Of Phys or this	5. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injur	y. 28b. T	ime of 28c	4 Nursing H Injury at Work?	dome 5 Res 28d. Describe		Other (Specific	(v)
ion ath. or: Aft	atio	1  Natural 5  Pending 2  Accident investigate	- 1	/ Year) Ir	njury M	Work? 1 ☐ Yes 2 ☐ No				
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the d within 24 hors/ after decided the second for the function of the function	Certification:	3 Suicide 6 Could not determined		ury - At home, far c. (Specify)	m, street, factory, o	ffice	28f. Location City or To	(Street and own, State)	Number or Rura	al Route Number,
spital		29a. Certifier 1 Certifying P	hysician: To the best of	of my knowledge.	, death occurred at	the time, date and place	a. and due to the	a cause(s) a	nd manner as si	tated
in 24 h	Medical	(Check only 2 Medical Exe	miner: On the basis of and manner sta	examination and	d/or investigation, in	my opinion, death occi	urred at the time	, date and p	face, and due to	the cause(s)
To t To t Com	Σ	29b. Signature and mile of certifier	m			icense number		29d. Date	signed (Month,	Day, Year)
	}	30. Name and address of person who	1)	eath (Itam 33a) /		3830		Aug	ust 12,	2006
5		JEFFREY BROWN M				RM. 4890	TOWSON,	MD 2	1204	
Star		31. Date fifed (Month, Day, Year)	20 1	4- 0'	Sperte					
Registra	ır	AUG 1 5 2	UUO JAPAN	C 15.	Children of the Control of the Contr					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item#3, per, MD, g858, 8/15 / 06 TT Cartificate of Death Certificate of Death Reg. No.ant's Name (First, Middle, V 2. Date of Death **Physician** /Medical Name (If not institution, give stree Jown, or Location of Death 4c. County of Deat Examiner BALLIMORE If Under 1 Year | If Under 24 Hrs. If Under 1 Year (In vrs. last birthday) 6. Sex 8. Date of Birth 9. Birthpla (State or Foreign **Funeral** 1 M 2 F Days Hours Min. Yrs. Director Usual Residence of Decedent 10b. County 10a State Gity, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Medical Exactiner must be notified at 1 Pres 2 No Director 10g. Citizen of What-Country Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White\_etc, 11. Marital Status 1 Never Married 2 Married 5 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3. Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during life, PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) most of working and Mental Hygiene. Elementa Secondary (0-12) Mage (1-4 or 5+) Be ind 2

yeartment of Health a.
Important: If item 27 Is:
any injury or other trevenence. ace of Disposition (Name of Method of Disposition 14☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral/Service License 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Richardanda /Medical Due to (or as a consequence of): **Examiner** S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) Oue to (or Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Wheeler Glody IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 4☐Pregnant at time of death Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? tapotry rold so 24a. Was an autopsy perform 1 🗌 Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation M 1 Yes 2 No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 8/8/06 00059056 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) st MT Royal 31. Date filed (Month, Day, Year) 1600 MO 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 1 5 2006

		ŀ	For State Registrar	State of Maryland	/ Depai	rtment of h	Health and M	Mental Hygiene	2006	25643
	Physicia	an	1. Decedent's Name (First, Middle, Las Frances M. Wat:					2. Date of Death Month Da	y Year	3. Time of Death
100 miles	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	40	County of Deat	h
~	Funeral Director		5. Social Security Number 6. Security Number 1		st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year, Nov. 11,		hplace (State or Foreign untry) aryland
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo		Town or Loc nn Oal					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the a or 28e Lee noti	Direc	10e. Street and Number 3806 Arbutus A			10f. Zip Code 21207			itizen of What Co	untry? s of America
326	s 1 and 2 should be filed within 72 hours after death with the Maryland i Health and Mental Hygiene. Item 27 Is marked other then "natural", or Iteme 23a or 28e-f ehow other traumatic event, the Madical Examinations and interest continual to a rotified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			Hispanic Origin? (Si an, Mexican, Puert Specify:		14. Race - Ame Black, White Specify: Wh	ncan Indian, e, etc.
Maryland 21215-0036	within 72 hou ene. then "natura he Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occu ind of work done O NOT use retire	during most of wor	king	Kind of Business	
nd 2	be filed within ital Hygiene. Id other then event, the Ma	Be	17. Father's Name (First, Middle, Last) Marshall Leonard					ne (First, Middle, Maide ce Leonard		
aryla	2 should be and Mental Is marked c	T	19a. Informant's Name/Relationship	Type, Print) –Law	19b. Mailing	Address (Stree		ral Route Number, City	or Town, State, 2	Zip Code)
Baltimore, M	Page nent o ant: If any or		Claude L. Willia  20a. Method of Disposition  X Burial 2 Cremation 3 C  4 Donation 5 Other (Specify	20h Bla	ce of Dispos netery, crem .awn Ce	ation (Name of atory or other pla emetery	08/14	Date 20c. t	ocation - City or 11awn , Ma	ryland
Balt	permit. Departr Importa		21. Signatur Funeral Service Licer	S88				ring Byers l Randallsto		Directors,In and 21133
760,	Physician /Medical Examiner per price property per per per per per per per per per per	Ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the short of th	b. Due to (or as a conseque  c. Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque  d. d.	ence of):	It cont	rng, such as cardiac			Approximate Interval Between Onset and Death
O. Box 68	ath certifica attending pt for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 🗆	Ectopic pregnand Other (specify)	су		23d. Date of de Month	ivery Day Year
rds, P.O	w requires that the de been signed by the a should be detached t	δ	Part II. Dther significant conditions of	contributing to death but not resul	ting in the un	derlying cause g	iven in Part I.	23e. Did tobacco	_	the cause of death?
Il Records,	The law recate has been page 2 sho	Completed						24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of
Vital	Physicien: The this certificate har director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	3 DOA	the area	ath (Check only one)  flome 5 Residence	6 ∏Other (Spe	ocity)
ion of	fing Ph I. After th funeral		27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe how inj		
Division	in Dir	Certification;	3 Suicide 6 Could not be determined	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office					and Number or R te)	ural Route Number,
	• Hospital or 24 hours afte • Funerel Dir etely filled in I	Medical		nysician: To the best of my know niner: On the basis of examinati and manner stated.						
)	To the within 2 To the complete	Me	29b. Signature and title of certifier				nse number		ate signed (Mon	th, Day, Year)
	St Regist	ate	30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death (Item  32. Registrar's Signati	23a) (Type,					21133
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DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Certificate of Death	Menta	l Hygie Reg.	I U U U	25644				
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date Mor	of Death	Day Year	3. Time of Death				
	Physici /Medic		Borgera weaver		ust	12 200					
	Examin	er	4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Dec	ath	4c. County of Death						
			Future Care-Cherrywood Reisterstown 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year I ff Under 24 Hi	rs I a Date	of Birth	Balti					
b	Funeral Director		219-32-9596 1 M 2 N F 68 Yrs. Months Days Hours Mi	n. (Mor	of Birth orth, Day, Ye -22-1		rthplace (State or Foreign ountry) aryland				
	death with the Maryland ms 23a or 28a-f show critist be notified at	<u>,</u>	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   Baltimore   Woodlawn				10d. Inside City Limits 1 ☐ Yes 2 ☑ No				
	Sa-f	Director			10:	0					
	with t	吉	10e. Street and Number 10f. Zip Code		10g.	. Citizen of What C	ountry?				
	eath	era	7405         Shirley         Road         21207           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent of Hispanic Origin?	(Specify Yes	s or No-	USA 14. Race - Am	erican Indian.				
	of within 72 hours after death with the Marylan jiene. Then "naturel", or tiems 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Put If Yes, Give Year or Dates:	erto Rican, e	itc.)	Black, Wh	frican- American				
<u>ج</u>	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of work done during	orkina	16	b. Kind of Business					
7	within 72 ene. then "net te Medic	Completed	College (1-40r5+)   Math Teacher	9	)	albrook					
	Hygien Hygien other th	So	5+			igh Sch	ool				
בב	be fill hate H by out	Be	17. Father's Name (First, Middle, Last)  Clarence A. Gee  Berth			iden Sumame)					
ž	hould d Mer nark natic	은				ity or Town State	Zin Cada)				
Maryland 2121	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, in QDCE.		Dr Carland R Weaver Tr			25.					
စ်	Heal Heal tem 2	1 8	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	200	c. Location - City o	r Town, State				
Baltimore,	ages ant of at: If I		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ State (Specify) Druid Ridge 8/1	19/06	Р	ikesvil	le MD				
	entre ortan injur	- 4	21. Signatur Fineral Swice Licensee 22. Name and Address of Facility	Wylie	F/H	P.A. o	f Balto. Co				
ñ	Depermine Depe		9200 Liberty Rd								
			234 Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as card shock, or heert failure. List only one pause on each line.	iac or respira	atory arrest	,	Approximate Interval Between				
	Physician		Immediate Cause (Final								
Н	/Medical Examiner		resulting in death)  Due to (or as a consequence of):								
	Examiner		Sequentially list conditions, b								
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
	and and al-trar	xan	that initiated events c								
09/89	ificate be executed physicien and is the burial-transit	calE									
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	ires that the death certifi signed by the ettending I be detached for use as	Physician/M	IF F6MALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnent at time of death 5 ☐ Other (specify)	- W		23d. Date of de Month	elivery Day Year				
ت	that the by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236	a. Did tobac	co use contribute t	to the cause of death?				
Vital Records,	quires n sign ald be	d by		_	1 🗌 Yes	20 No 3 P	robably 4 Unknown				
င္ပ	iaw requires that the as been signed by th 2 should be detache	ompleted		248	ı. Wasan	24b. Were a	utopsy findings available completion of cause of				
Ĕ	0 5 0	E		10	autopsy performed Yes 2/2	d? death?	s Mo				
ā	ilcian: Th certificate rector, pag	O	25. Was case referred to medical 26. Place of D	-		110	3 Jan 140				
>	nysici nis ce direc	To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: Wursing	Home 5	Residenc	e 6 Other (Spe	ecify)				
on of	Attending Physician: r death. ector: After this certifica by the funeral director, p		27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  Injury M  1 Yes 2 No	28d. De:	scribe how	injury occurred					
=	2550	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)	281. Loc City	ation (Stree or Town, S	et and Number or F State)	Rural Route Number.				
	To the Hospital or At within 24 hours efter of To the Funarel Direct completely filled in by	Medical C	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla (Check only one)    Check only one   Check only   Chec	ce, and due curred at the	to the caus e time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)				
	To the within To the Comp	ž	29b. Signature and title of certifier 29c. License number		29d.	Date signed (Mon	th, Day, Year)				
	1		Cle 1 0 2908	5	n	J	14 2000				
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
	1		Allen J- Chicaus M.D. 3310 0	0 6	CUrt	Reas	21133				
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 1 5 2006  32. Registrar's Signature								
	negisti	al .	AUGI 5 2006   Berger D. Sporte								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** 26 аМ 2006 12:32 July Harold Aislev /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Hospice Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 22, 1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F Massachusetts 90 564-18-6872 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County or than "natural", or itsms 23a or 28a-f show tre Madical Exerciting must be notified at 1 ☐ Yes 2XXNo Director Annapolis Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 845 Deerwood Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No White Specify Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygiens important: if tem 27 ie marksd other tha sny injury or other traumatic event, ITEL ODGE. Foreign Service Diplomat State Department 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sara Mintz Julius Aisley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 845 Deerwood Court, Annapolis, MD 21401 Barbara Ellen Aisley (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7-27-2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Inset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. D1151311813 MARTHAY Immediate Cause (Final JATRAOSCLENOTIC COMMANY Y151719 Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 4 Unknown 1 Tes 2 No 3 Probably Completed certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 220No To the Hospitel or Attending Physician: After this certific funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be 140511613 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c 1 Matural 5 Pending investigation 1 Yes 2 No М r death. within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier D08118 26 2006 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) BASTGATE THE ANNADOUS KINS 900 TLET 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

DHMH 17 Rev 1/2001

**ORIGINAL** 

		•	For State Registrar	State of Maryla	•	artment of H			ene 3. No. 2006	25546
	nysicia	_	1. Decedent's Name (First, Middle, Last) Lillie E. Alexan	der				2. Date of Death July 2	6 <sup>Day</sup> 2 <b>0℃</b>	3. Time of Death 6:15Р м
	Medic xamin	er	4a. Facility Name (If not institution, give st Anne Arundel Med	ical Cente		Annapo			4c. County of Dea Anne Ar	undel
	neral ector		5. Social Security Number  212-36-5981  Cusual Residence of Decedent	7. Age (In yrs	72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) June 8	<sup>9. Bir</sup> 1934 Mar	thplace (State or Foreign ountry) Tyland
Maryland	ified at	ğΝ	10a. State 10b. County Iaryland Anne Aru		ity, Town or Lo					10d. Inside City Limits 1 → Yes 2 → No
th with the 23a or 28a	let be not	Funeral Direc	10e. Street and Number 55 Clay St.			10f. Zip Code 21401		104	g. Citizen of What Co USA	ountry?
5-0036 72 hours atter death with the Maryland natural: or Items 23a or 28a-t show	event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit Specify:	
vithin 72 ho liene.	• Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired y Care	during most of world)	king	Self Empl	
Maryland 21215-0036 td 2 should be filed within 72 hours att tth and Mental Hygiene. 77 is marked other than "natural" or	c svant, th	To Be Co	9th 17. Father's Name (First, Middle, Last) Issac Bias		Da	y care		ne (First, Middle, Ma	•	
	tre	F	19a. Informant's Name/Relationship (Type Paul Alexander (F	lusband)	55 C	lay St.	Annapol	ral Route Number, Lis, Md.	City or Town, State, 21401	Zip Code)
0 80			20a. Mathod of Disposition 1 ∰ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b.	Place of Dispo Bestoria	osition (Name of Between other place 1 Park	8-1-		oc. Location - City or nnapolis	
Baltimoperant: Pag	any injury o			ese MOOS	83 8	21 West	St. Ann	napolis,	ry, P.A. Md. 21	101
Physi /Med Exam	dical	- C	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to for as a conse	equence of):	_ '	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
68760, ifficate be executed and on by sician and	pnysicien and s the burial-transit	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conse						
ath certif	led by the attending priy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3[	□Ectopic pregnancy □ Other (specify) _	/	-	23d. Date of de Month	olivery Day Year
rds, P	should be deta	by	Part II. Other significant conditions cont	ributing to death but not ri	esulting in the u	inderlying cause giv	ren in Part I.	23e. Did toba	_/	o the cause of death? robably 4 □Unknown
	page 2	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	utopsy findings available completion of cause of
n of ng Phys	ner	Certification: To Be	27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier  28b. Time of Injury	of 28c. Injur	ner: 4 Nursing H	28d. Describe how	nce 6 Other (Spe w injury occurred	
	lled in by t		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cily) 			City or Town,		
Di To the Hospitel or within 24 hours after	To the Funeral Direct completely filled in by	Medical		er: On the best of my ker: On the basis of examinand manner stated.			opinion, death occu	irred at the time, da		e to the cause(s)
T × F	¥ 8				Iom 22-1 /T	000	5(301		Tuly 26	2000
	Sta	ate	31. Date filed (Minth, Day, Year)	2. Agistrar's Sig	7 70	DO Per	199te 9	#300	Annypo	15 MD 214
· R	legisti	ar	JUL 3 1 2	306	No A					

DHMH 17 Rev 1/2001

# 23 A Anne Strundel

			1 - For State Registrar	State o	f Marylar		artment rtificate			and M		Reg. No.	006	25647
	Physici	an	1. Decedent's Name (First, Middle		17.120						JULY 3		< Year	3. Time of Death 9:05 A M
	/Medic	al	JOSEPH 4a. Facility Name (If not institution	BAYARD	ADAMS	5	4h City	Tourn or	Location of	of Death	JULI J		nty of Death	9:03 A M
	Examin	er	2608 TALBOT COU	_	mb <del>u</del> r)			IALDO		) Death			HARLES	3
-	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt	h Year)		place (State or Foreign
	Director		218-38-8168	1 <b>∑</b> M 2□F	63	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da APRIL	30, 43	WAS	HINGTON DC
	pue M		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Manyli f eho	ō	MARYLAND CHAR	RIFC		,			WAL	DORF				1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number	CILLO			10f. Zip	Code				10g. Citizen	of What Cour	ntry?
	th with 23a o	al D	2608 TALBOT COU	JRT				20	602			UNIT	ED STA	TES
	r dea	Funeral	11. Marital Status	Armed Fo	edent Ever in U prces?	J.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Americ Black, White,	
36	rs afte	by Fi	1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 📉 Yes tf Yes, Gir Year or D	ve .	961 966	1 ☐ Yes 2	No 🛣	Specify:			Spe	cify:	HITE
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Iteme 23a or 28a-f ehow int, the Mickeal Exampler must be notified at	ted	15. Deceden	t's Education	1.	16a. Dece	dent's Usua	i Occupa	ition			16b. Kind o	f Business/In	
215	hin 7.	ple	(Specify only highes Elementary/Secondary (0-12)	college (	1-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired,	lu <i>ring</i> mosi )	t of worki	n <i>g</i>			
7	ygien ygien ner th	Completed	12				SALE	SMAN					CARPET	
and	be fill bd oth	Be	17. Father's Name (First, Middle,								(First, Middle, E.S. RA		nam <i>e)</i>	
Maryland	should be land Mental I s marked o	<u>٢</u>	GEORGE BAYARD A  19a. Informant's Name/Relations			19b. Maili	na Address	(Street a			I Route Numbe		wn. State. Zic	Code)
	nd 2 alth ar 27 is 27 is or trau		STEPHANIE ADAMS	S- WIFE		2608	TALBO	OT CO	OURT,	WAL	DORF, M	IARYLAN	ND 2060	02
ore,	es 1 a of He f item r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □ Bomoval from	1	Place of Dispo cemetery, crei	sition (Nam	ne of ther place	9)	AUGŪ	ST ST	20c. Location	on - City or To	own, State
Ĕ	Pages ment of lant: If its		4 □ Donation 5 □ Other (S	pecity)	PA	RKLAWN	CEME	rery		3, 2		ROCK	/ILLE,	MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Inportant: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow eny hiptry or other traumatic event, I'm Michical Exacilinal manks notified at once.		21. Signal relof Fureral Service	Moham	MQ0053		UNTT ]			•	P.O.BC	X 156,	WALD	20604 ORF, MD
Г			23a. Part 1 Enter the disease, or shock, or heart failure. List	complications that only one cause on e	caused the dea each line.	th. Do not ent	ter the mode	e of dying	g, such as	cardiac c	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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	death e atte ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregr	oirth 2 ☐ Feta nant at time of a		□Ectopic pro □ Other (sp						Month	Day Year
P.O.	at the by th	hys	9 🗆 Unknown	9□ Unkn										
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Re	he lav e hes age 2	duic									autop	rmed?	death?	mptetion of cause of
ta	Physicien: The this certificete he ral director, page	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	ne)	1 🗆 Yes	2 □ No
<u>&gt;</u>	Physic this ce al direc	ToB	examiner? 1 Yes 2 No			ER/Outpatier	nt 3□ DQ	A Othe	or: 4 □ Nu	ırsing Ho	me 5 Resid	dence 6 🗀	Other (Specif	<b>'y</b> )
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isio	r Attending Per death.	icat	2 Accident investig	not be	of Injury - At h	nome farm st	M factors		/es 2□		28f Location /	Street and Ni	mher or Rue	al Route Number,
≧	i Diffic	Certification:	4  Homicide determ	build	ing, etc. (Speci	fy)	eet, factory	, onice			City or Tov	vn, State)	anos or right	i noate realiber,
	To the Hospitel or within 24 hours afte To the Funeral Dirr completely filled in I	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the b and man	e best of my kn easis of examinates	owledge, deat ation and/or in	h occurred a vestigation,	at the tim	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and date and plac	manner as s ce, and due to	tated. o the cause(s)
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	00		30. Name and address of person					ЛО	00 **	7 A T T\ C	ante ser	20.00		
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		4	For State	State	f Marylan		artment				lental F	lygiene Reg. No	ZHHHK	25643
		15 mg	Registrar  1. Decedent's Name (First, Middle)	le, Last)							2. Date of	Death		3. Time of Death
	Physicia	in									Month 7	Day 31	y Year 2006	1130 M
	/Medic Examine		Brian Appleto  4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City,	Town, or	Location	of Death		4c.	County of Dea	
	Fydillin	4	Atlantic Gener	ral Hospit	:a1		Ber	lin					orceste	r
	Funeral		5. Social Security Number	6. Sex 1 <b>3</b> M 2 ☐ F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, Year)	9. Bir Co	thplace (State or Foreign country)
	Director		196-48-7737	1L <b>X</b> M 2UF	49	Yrs.					1/14	/1957		PA
	pug *	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Limits
	Aaryli I sho	ō			M	ohntor	,							1 ☐ Yes 2 No
	28e-	Completed by Funeral Director	PA Berl	KS	F1	IOIIIICOI	10f. Zip	Code				10g. Cit	izen of What C	ountry?
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	death ms 2:	era	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.	Was Deced		ispanic O	rigin? (Spe	ecify Yes or		14. Race - Am-	
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ano	d be f nital h ed of	) Be	Melvin R. Appl						Кa	thle	en Bro	NW11		
Maryland	should and Me mark matin	ဥ	19a. Informant's Name/Relation			19b. Mail	ing Address	(Street					or Town, State,	Zip Code)
≥	nd 2 s lith ar 27 is r treu		Kathleen Apple	eton (wife	2)	3 A1	bor R	d.,	Mohn	ton,	PA 19	545		
<u>စ</u> ်	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23s or 28e-1 show eny injury or other treumatic event, I're Modical Exerting Instituted at once.		20a. Method of Disposition		20b. I	Place of Disp cemetery, cre					Date		ocation - City o	r Town, State
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			23a. anti. Enterine disease, o shock, or heart failure. Lis	or complications that st only one cause or	caused the dea	th. Do not en	nter the mod	le of dyin	ng, such a	s cardiac	or respirato	ry arrest,		Approximate Interval Between Onset and Death
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5r, 737 Vital	ien: rtifica ctor, p	Be C	25. Was case referred to medic examiner?	cal						ce of Dea	th (Check o	nly one)		
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-1 1	ng Pl	on:	27. Manner of Death 1 Natural 5 ☐ Pend	/A Ac	e of Injury onth, Day Year)	28b. Time Injury		28c. Injui Wo		TN:	28d. Desc	ribe how inji	ury occurred	
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Apple 146-48	or Att	Certification:		280, Pla	ce of Injury · At I Iding, etc. (Spec	nome, iarm, : cify)	street, ractor	у, опсе			City o	r Town, Star	re)	ing rious realization,
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B	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edicai	(Check only 2 Medic	al Examiner: On the	basis of examir	nation and/or	investigation	n, in my	opinion, d	eath occu	rred at the t	me, date ar	nd place, and di	ue to the cause(s)
	To the within 2 To the Comple	Med	29b. Signature and title of perti	A	11		29	c. Licens	se numbe	r		29d. D	ate signed (Moi	nth, Day, Year)
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			30 Name and address of person	on who completed ca	use of death (Ite	am 23a) (Typ	e, Prings	111	1		. /	7/1		206/1
,	ET 10		Anthony 5	-Vercla	M4).	1733	110	ilth	War	11/1	wo /	rerlu	a INI	1 <1011
1		ate	31. Date filed (Month, Day, Yes	,	Registrar's Sign		1 -							
1	Regist	rar	AUG	2 2006	Blace	D.	grade							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 28, **Physician** Mabel Eileen Anderson 2006 1811 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Worcester Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3-19-1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2K□ F Baltimore Yrs. 78 Director 216-20-6280 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County with the Marylan 7 ie marked other then "natural", or items 23s or 28a-f shov traumatic event, ins Medical Examinar musi be nutified al 1 Yes 2 No Whaleyville **Funeral Directo** Worcester 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number 21872 US 8133 Old Ocean City Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Specialist Hospitality 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edith Chaffman Clarence W. Carre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HC 64, Box 2309, Romney, West Virginia 26757 Barbara Bonat DDO Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 8-1-2006 Berlin, Md. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, Md. 21811 3a. Part 1. Enter the disease, or condications that couled the coath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death clostridium difficile colità Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine acute renal tailure ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): // Control of the No. Box 68760, Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 NO 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 2 **3 1**0 1 Hnpatient 2 ER/Outpatient 3 DOA 1 Tes After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No Hospitel or Attendi 24 hours after death. Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel E 1 Dentitying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

6 State Registrar

DHMH 17 Rev 1/2001

29b. Signature and

AUG 0 1 2006

MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



29c. License number

1)53612

Dr. Berlin, MD 21811

29d. Date signed (Month, Day, Year)

7/28/06

## Please Type or Print in Black Indelible Ink

George H. Baines	1- For State Registrar	State of Marylan					eg. No. 200	6 25650
Physician/ Medical Examiner	1. Decedent's Name (First, N	,,				2. Date of Dea Month June 22, 2	th	3. Time of Death 1423 hrs
	4a. Facility Name (if not instri Peninsula Regiona	ution, give street and numb	per)	4b. City, Town, Salisbury	or Location of De		4c. County of Dea	
Funeral Director	5. Social Security Number		Age (In yrs. last birthda	ay) If Under 1 Y Months D		lin.	th(MM/DD/YYYY) 9. E	eign
any	224–28–8336  Usual Residence of Deceder  10a. State 10b. Cou		10c. City, Town or	Yrs.		June 14	, 1924	Country) VA
*	MD 17	ester	Westover	Location				10d Inside City Limits 1 Yes 2 X No
uth the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 32650 Coston Ro	ad		10f. Zip Code 21871		1	0g. Citizen of What Co	untry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Madical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 V	Married 12. Was Deceded Armed Force 1 y Yes		3. Was Decedent of If Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)		erican Indian, Black,
nours after natural", xaminer sed by F	Widowed 4	Divorced If Yes, Give Year	completed) 16a. Dec	cedent's Usual Occup	No specify: pation (Give kind o	of work done	Specify: B1	ack s/Industry
5-0036 led within 72 hour bour bygiene other than "natu the Midical Exan Completed	Elementary/Secondary (0-		or 5+) Por	ing most of working l	fe. DO NOT use r	etired)	Super Giant	Foods
MD 21215-0036 nd 2 should be filed within 7 sith and Mental Hygiene m 27 is marked other than aumatic event, the Medica To Be Comple	Henry Baines				18.Mother's Na Marrie Dov	me (First, Middle, M Ining		· · · · · ·
MD 21 d 2 should th and Me th and 27 is ma umatic ev	19a. Informant's Name/Relati Mildred Hayward			lailing Address (Str 76 Hayman Dr			iber, City or Town, State	e, Zip Code)
Baltimore, bernit. Pages I an Department of Hea Important: If iten njury or other tra	20a Method of Disposition  1 X Burial 2 Crema		State crematory	isposition (Name of or other place)		Date	20c. Location - City o	
Baltir permit. E Departme Importai	4 Donation 5 Other 21. Signature of Funeral Services H. Bannist	ice Licensee	I New Alle	n Memorial A 22 Name and Addre P.O. BOX 17	ss of Facility Jo	n O. Morri	Franktown, s Funeral Nor 413	e, Inc.
Physician /Medical	23a. Part I. Enter the disease failure. List only one cau	or complications that caususe on each line.		nter the mode of dyin	g, such as cardiad			Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disea or condition resulting in death	Due to (or as a cor	Atherosclerotic C	ardiovascular D	isease			Death
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate	Due to (or as a cor	nsequence of):					
be executed be executed sician and urial - transit	events resulting in death) La		nsequence of):					
760, cate be execu physician and the burial - tra	UNPENDED  IF FEMALE:	23c. If yes, outo	tem#21, perFH,	G858,8/15/06	5 TT		23d. Date of deliver	N N
Box 68760 be death certificate the attending phys ted for use as the bu thysician/Me		1 Live birth 4 Pregnant 9 Unknown	at time of 5	Fetal death 3 Other (Specify)		nancy		Day Year
s, P.O. irres that the signed by I be detach	Part II. Other significant con	ditions contributing to de	ath but not resulting in	the underlying cause	given in Part I.		2 No 3 Pro	
Division of Vital Records, P.O. Box 6876C to the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the by edical Certification: To Be Completed by Physician/Me	25. Was case referred to med					24a. Was a autops perforr 1 Yes 2	y prior to death?	utopsy findings available completion of cause of es 2 No
f Vital Physician or this cert ral directo	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	tient 2 🗸 ER/Outpa	tient 3 DOA	Other Nurs		Residence 6 Othe	r.
ivision of or Attending I after death. Director: Afte I in by the funer tification:		28a. Date of Ir (Month, Day ending vestigation	njury (,Year)		ury at Work? Yes 2 No	28d. Describe ho	ow injury occurred	
Division o spital or Attending hours after death. The real Directors After filled in by the fune Certification:	4 Homicide	ould not be etermined (Specify)	Injury - At home, farm,	street, factory, office	building, etc.	28f. Location (St or Town, Sta		ıral Route Number, City
D To the Hospital within 24 hours. To the Funeral completely filled	29a. Certifier 1 Certifying one) 2 Medical E	Physician: To the best of xaminer: On the basis of examiner state	camination and/or inves	occurred at the time, octigation, in my opinio	date and place, ar n, death occurred	d due to the cause at the time, date a	(s) and manner as star nd place, and due to th	ted ne cause(s)
W	29b. Signature and title of cert				se number		29d Date signed (Mo	nth, Day,Year)
	30. Name and address of pers Ana Rubio MD. A	on who completed cause of ssistant Medical Exa	, -,	n Street, Baltim	ore, MD 2120	<u>_</u> )1		
State Registrar		5 2006 32 kegisti	rar's Signature	poste				-

		1	For State Registrar	State of M		epartm Certific		lealth and N Death		jiene eg. No.	006	256	51
			1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physicia /Medic		Rena Chumas Bilbo						Ju1y	27	2006	5:10	A M
1	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. C	ity, Town, or	Location of Death		4c. Co	ounty of Death		
			Atlantic General		"		lin der 1 Year	If Under 24 Hrs.	8. Date of Birth		rcester	place (State o	r Foreign
	Funeral		5. Social Security Number 6. Second 1	M 2□XF	ge (In yrs. last birti 62 `	Mon		Hours Min.	(Month, Day 10/1/19	Year)	Cour	ngton,	
	Director		214-42-6740 Usual Residence of Decedent		02				10/1/1	45	Wasiii	ng con,	Б.О.
	yland sow		10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside Cit	
;	Mar	jo	Maryland Worceste	r	Ber1	in						1 🗆 Yes	2 <b>™</b> No
	or 28	Directo	10e. Street and Number			10f	Zip Code			10g. Citize	n of What Cour	ntry?	
	23a	rai	4 Dogwood Place				21811				d State		
9	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther then "naturel", or iteme 23s or 28s-f show event, the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 A If Yes, Give Year or Dates:	?	1	ecedent of H specify Cuba s 2 1 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		. Race - Americ Black, White, pecify: Whi	etc.	
9500-61212	hour furel	ed t	15. Decedent's Ed		16a.	Decedent's	Jsual Occup	ation		16b. Kind	of Business/In		
Ċ	n 72	Completed	(Specify only highest gra			(Give kind o life. DO NO	work done	during most of worl	king				
212	r the	E	Elementary/Secondary (0-12)	4		gister	ed Nu	rse		Nur	sing		
פַ	e filed il Hygi other vent,	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle,	Maiden Su	umame)		
<u> </u>	should bind Menta	2	James N. Chumas					Viola F	hiaras				
Maryland	2 sho and is mu		19a. Informant's Name/Relationship (	Type, Print)	19b.	Mailing Add	ress (Street	and Number or Ru	rai Route Numbe	r, City or 7	own, State, Zip	Code)	1
	and and ealth m 27 m		George W. Bilbo J	r./Husban	d 4			ce. Berli	n, Mary		21811 ation - City or To	State	
0	Pages 1 nent of H int: If ite iry or otl	Ιí	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	y, crematory	or other plac	ce)					1
Baltimore,	tmen tant:		4 Donation 5 Other (Specify	-	St. Demo	etrios (	emetery	ss of Facility Ge	/2006	Anna <u>l</u> Kalas	oolis, l	daryia:	na e
Bal	permit. Pages 1 and 2 should Depertment of Health and Men Important: If Item 27 Is marke eny injury or other traumatic once.		21. Signature Funeral Service Licen	590				nons Isla:					
			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do r							Approximat	е
			shock, or heart failure. List only Immediate Cause (Final	oné cause on each l	line.						101.1	Interval Bet Onset and I	
-	mysician /Medical		disease or condition resulting in death)	a. Due to (or as	s a consequence	of):	- (u	anones	g-in	John	+ predu	2 gr	de
	Examiner								V.			10	
		Je.	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	Due to (or as	s a consequence :	of):							
	acuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		- 0							
760,	ate be executed hysician and the burial-transit		resulting in deatily cast	Due to (or as	s a consequence	or):							
87	physicate by the t	dlcal		d									
9 X	leath certific ettending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy					23	d. Date of deliv	ery	
Вох	etter for u	clar	in the past 12 months? 1 ☐ Yes 2 Ø No		2 ☐ Fetal death at time of death		r (specify)	y 			Month	Day '	Year
o	t the c by the achec	hys	9 Unknown	9□ Unknown					-	i_			
Records, P	The law requires that the death certifics ate has been signed by the ettending ph bage 2 should be detached for use as it	Ď	Part II. Other significant conditions of	ontributing to death	but not resulting in	the underly	ng cause giv	ven in Part I.		bacco use ′es 2□	e contribute to t	3.7	death? , Unknown
000	aw require as been si 2 should b	Completed							24a. Was		24b. Were auto	opsy findings ompletion of a	available ause of
č	The lav ete has page 2	mo:							perfo	rmed? 2 No	death?	2 No	
ita	iician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?						ith (Check only o	ne)			
<u>~</u>	Physic this c	၉	1 ☐ Yes 2 No	Hospital: 1 / Inpat			DOA Oth	4   Nursing H	ome 5 Resid			fy)	
ň	ding P	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D		Time of njury M	28c. Inju	ryat rk? ]Yes 2 ∐No	28d. Describe h	iow injury	occurrea		
isio	Attending Physician: r death. ector: After this certifice by the funeral director. I	cat	2 Accident investigation 3 Suicide 6 Could not b		njury : At home, fa			1163 2 1110	28f. Location (S	Street and	Number or Rur	al Route Nuп	nber.
Division of Vital	al or Attens s after death il Director: ed in by the	Certification:	4 Homicide determined	building, e	etc. (Specify)	, 411001, 12	o.o.y, oo		City or Tov	vn, State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (		nysician: To the bes niner: On the basis and manners	of examination an								s)
	within 2 To the F complete	Me	29b. Signature and title of certifier				29c. Licens	_		29d. Date	signed (Month,	Day, Year)	
)			1 Het mil				110	05081	6	7/2%	7/06		
			30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)				/ /			
			Razaak Eniola Atlantic	General Ho	spital 97	33 eal	hway D	rive, Berli	n, Maryla	nd 218	811		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	BOE Jogis	trar's Signalite								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2006 0930 Lucille Depew Barnes July 28 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Center Westminster Westminster Nursing and Rehabilitative Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 18 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days Hours Kentucky 1 □ M 250 F 90 216-16-5572 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carrol1 Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 723 Hook Road 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leonard Carl Depew Oma Mae Shell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elkridge, MD Anna McKissick/daughter 5945 Hunt Club Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Meadow Ridge Cemetery 8/01/2006 Elkridge, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wonan orten disease or condition resulting in death) Due to (or a a onsequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4. Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 04 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

the attending physician and hed for use as the burial-transit death certificate be executed

signed by the a

certificate has

of or Attending Physicien: after death. Director: After this certification

To the Hospitel 24 hours

within 2 To the

WIL

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Box 68760

P.O.

Division of Vital Records,

Examiner

Physician/Medical

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Completed

Be

Certification: To

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

'neturel', or Items 23a or

Hygiene.

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Importent: If tem 27 is marked other the any injury or other traumair

death v

Baltimore, Maryland 21215-0036

Director

Funerai

þ

Completed

Be

other traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

	1 ☐ Yes 2 ☐	10	1 🗆 Yes	2 🗆 No
Place of Death (C.	heck only one)			
Nursing Home	5 Residence	6 🗆 0	Other (Speci	ify)

1 Tyes 27. Mann of Death 1 Watural 5 Pending

2 Accident

(Check only one)

29a. Certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) investigation

Other: 4 28c. Injury at Work? 28b. Time of Injury 1 Tyes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28d. Describe how injury occurred

6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medicai

29b. Signature and thie of certifier Ernesto Mendoza, MD

Do0 50763

ERNESTO

29d. Date signed (Month, Day, Year) 31/06

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print) 686

MENDOZA.

State Registrar 31. Date filed (Month, Day, Year) AUG 0 1 2006



State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 0630M **Physician** 2006 /Medical County of Death 4b. Cay Town, or Location of Death Facility Name (If not institution, give street and number) Examiner schorage alisbur icomico ð If Under 1 Year | If Under 24 Hrs. 7(Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 7, Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days Hours **№** M 2□ F 48 Pennsylvania 213-64-6440 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Mudical Exer uper Local be mutified as once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Virginia Accomack 1 ☐ Yes 2 ☐ No Chincoteague Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6392 Vacation Park Lane 23336 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Photography Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Henry Brown Jean L. Mobley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dixie Brown Hughlett, sister 27946 St. Michael's Road, Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 08/01/2006 Silver Run, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Sunature of Funeral Service Licenses M01191 ستلميه 91 Willis Street, Westminster, MD 21157 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASWA Physician 54 con /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Extra Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š cate has been sig 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 No death. 1 TYes 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WIL July 27 1 2006 005/359 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) SHISBURY MD 21804. 1415 S. DIVISION DR-USHA NATESAN 32. Regierar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 3

2006

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			Decedent's Name (First, Midd	ile, Last)							Date of Dea	th		3. Time of	Death
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	/Medic		4a. Fecility Name (If not institution		ımber)		4b. City, Tov	wn, or Lo	cation of		ту .		ounty of Death	1	
	Examin	er	,	. 3											
	_		Calvert Manor 5. Social Security Number	6. Sex		s. last birthday	Rising		1 f Under 2	24 Hrs.   8. (	Date of Birth	Cec		place (State or	Foreian
	Funeral Director		•	1 ☐ M 2 🖾 F		Yrs.			Hours	Min. (	Month, Day	, Year)	Col	untry)	
	Director		220-07-3345 Usual Residence of Decedent		86		L			<u>Ap</u>	ril 3	, 192	Ulvir	ginia	
	and		10a. State 10b. Count	у	10c. (	City, Town or L	ocation							10d. Inside Cit	y Limits
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	the h	ect	Maryland Ceci  10e. Street and Number		El	.kton	10f. Zip Co	ode				On Citize	n of What Coi	intry?	
	with a or	츱	TOB. Street and runiper									og. Onize	ii oi iiilat oo	and y :	
	ath v	Funeral Director	17 Raven Court				2192				, N		ed Sta		
	eb de	une	11. Marital Status	Armed F		U.S. 13.	Was Decedent If Yes, specify	Cuban, I	Mexican,	in? (Specify , Puerto Rica	Yes or No- in, etc.)	14	Race - Amei Black, White		
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밀	d oth	Be	17. Father's Name (First, Middle	i, Last)				18	B. Mother	r's Name (Fil	rst, Midale,	Maiden Si	ımame)		
<u>8</u>	ould be Mental arked o	P	Clyde F. Bram	mer					Laur	a Dods	son				
Maryland 21215-0036	2 should be and Mental Is marked raumatic av		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mail	ing Address (S	treet and	d Number	r or Rural Ro	ute Numbe	r, City or T	own, State, Z	ip Code)	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 Is marked other than "netural", or Itams 23e or 28e-1 show or other traumatic avant, I'm Medical Examiner must be notified at		Robert L. Ben	iamin.II/9	Son	108 8	Susqueh	anna	h. B1	vdNe	orth E	ast.	Maryla:	ad 2190	1
altimore,	of He of He fitam		20a. Method of Disposition		20b	. Place of Disp	osition (Name i	of ir place)	iΑ	ugust	3,	20c. Loca	tion - City or	Fown, State	
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			shock, or heart failure. Lis	st only one cause on	each line.		7339	125			opilatory arr	001,		Interval Bety Onset and D	veen
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	/Medical Examiner		resulting in death)		(or as a cons			:50							
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ó	be executed sician and burial-transit		resulting in death) Last	Due to	(or as a cons	equence of):									
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<b>₹</b>	nysici lis ce direc	70	1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	ent 3 DOA	Other:	Kyur	rsing Home	5 🗌 Resid	ence 6 (	Other (Spec	cify)	
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.0	e : at :			d not be 380 Plac	e of Injury - At	home, farm, s	treet, factory, or	ffice		28f.	Location (S City or Town		Vu <i>mber or R</i> u	ral Route Numb	per,
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			For State Registrar	State of N	Maryland	-	artment o			Mental Hyç	giene Rag. No.	06	256	55
(F)	Physicia	an	Decedent's Name (First, Middle	, Last)	Rend	ell				2. Date of Dea	Day 🗸	Year 2006	3. Time of De 710p	eath M
	/Medic Examin		4a. Facility Name (If no institution	, give street and number			4b. City, Tow	n, or Location	on of Death		4c. County			
May		gi (de	Coffman Nursir 5. Social Security Number	ng Home	Age (In yrs. la	st hirthday)	Hag If Under 1 Y	erstov	vn der 24 Hrs.	8. Date of Birtl			on Count	
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	or 28a	irec	Maryland Wash	nington		Ω	10f. Zip Co	de			10g. Citizen of	What Cour	ntry?	
	ath wit	raiD	1304 Pennsylva		<del></del>			21740				S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ship injury or other traumatic event, its Modical Extractional termolifications.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marri  3 Widowed 4 Divorced	12. Was Deceder Armed Force ied 1 Tes 2 [ If Yes, Give Year or Date:	s? <b>X</b> No		Was Decedent If Yes, specify t 1 ☐ Yes 2 🔀			pecify Yes or No- p Rican, etc.)	14. Had Bla	ce - Americ ck, White, y: Wh		
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Baltimore	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Licensee 7	4	1	2. Name and A	ddress of Fa	Blvd.	uglas A. N. Hage	Fiery	Fune:	ral Home	e 742
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	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Corthylin (Check only 2 Medical one)	g Physician: To the basis Examiner: On the basis and manner	s of examination	rladga, daal on and/or ir	n occurred at to ivestigation, in	ns tano, date my opinion,	death occu	, and due to the t rred at the time, o	date and place,	and due to	tated. the cause(s)	
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S	H-2		30. Name and address of person	who completed cause of	Taul	23a) (Type,		0. H	ogers	HIWN 1	MD 31	740		
le .	Sta Registi		31. Date filed (Month, Day, Year)	3 2006 32. R	strar's Signatu	uro	persi		•					

			1 - For State Registrar	State of Maryland		rtment of				giene Reg. No	006	25656
·	Physici	an	1. Decedent's Name (First, Middle, Last)  STANLEY	DAHAA					2. Date of Dea Month	Day	Year O G	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give st			4b. City, Town			07	4c. Cou	unty of Death	1
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approx.	Funeral Director		5. Social Security Number  579-48-9363  Usual Residence of Decedent	7. Age (In yrs. la	Yrs.	Months Day	rs Hours	Min.	8. Date of Birt (Month, Day 5/31/19		Cour	nington DC
	Maryland f ehow	ō	10a State 10b County	tgomery 10c. City,	Town or Lo	Silve	r Spr	ing			1	0d. Inside City Limits  1  Yes 2 □ No
	r 28a-	irect	10e. Street and Number			10f. Zip Code	9			10g. Citizen	of What Cour	ntry?
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030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene.  Maportant: If team 27 is marked other than "natural", or items 23a or 28a-f ehow any Injury of other traumatic event, I'm Medical Eraci, it arminal be rediffed at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW I	. 1	Vas Decedent o i Yes, specify Ci I □ Yes 2X N			offy Yes or No- Rican, etc.)		Race - Americ Black, White, ecify:	
Maryland 21215-0036	thin 72 ho e. en "natur Medicel	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occ kind of work dor OO NOT use reti	ne during mo	ost of workir	ng	16b. Kind o	of Business/In	dustry
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≥ ຜົ	1 and 1 and 1 and 27 1 am 27 1 her tr		Debbie Kushner - Da 20a. Method of Disposition	20b. Pla	ace of Disco:	Locust	1		Silver		on - City or To	
baitimore,	Pages nent of int: If it		1 Donation 5 ☐ Other (Specify)	moval from State Jud	metery, cren ean Me	natory or other p morial	olace)	7/28/	/06		y MD	
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	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death, e cause on each line.  Congest  Due to (or as abonseque					Rockvi r respiratory ar	lle MI	20852	Approximate Interval Between Onset and Death
	Medical Examiner whise price of the price of	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		onice of).							
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	lc. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregna Other (specify)				23d.	. Date of delive	ery Day Year
<b>1</b> .	es tha gned be de	d by	Part II. Other significant conditions cont	tributing to death but not resu	Iting in the ur	nderlying cause	given in Par	t I.	23e. Did to			he cause of death?
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VITE	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			0		(Check only o			
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_	r Attenter deat irector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, str				28f. Location (S City or Tox		umber or Run	al Route Number,
	To the Hospital or Att. within 24 hours after de To the Funeral Direct. Completely filled in by t	edicai C		ician: To the best of my know er: On the basis of examinati and manner stated.	ion and/or inv	vestigation, in m	y opinion, di	eath occurre	ed at the time,	date and pla	ice, and due t	
	Fo the Hos within 24 h Fo the Fun completely	Med	29b. Signature and title of certifier	and marries stated.		29c. Lice	ense numbe	г		29d. Date si	igned (Month,	Day, Year)
			kan	MD			Doos.	3700	7	7	126/	6
	>		30. Name and address of person who cor		23a) (Туре, U С	Print) allow	ñ	x le	a	STE	4	210 1300
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 1 2	32. Pogistrar's Signat	J. A	certi					M	1) 20715

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Date of Death
 Month

July 27,

Day

2006

4c. County of Death Montgomery

4:30

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		٠.	209 Hill	209 Hillsboro Drive					lver	Spri	ng		1	Mont	gome	ry	
	Funeral		<ol><li>Social Security Nur</li></ol>		Sex	7. Age (In y	rs. last birth		der 1 Yea		r 24 Hrs. Min.	8. Date of B	irth		9. Birth	nplace (State untry)	or Foreign
	Director		173-20-77	26	1 <b>3</b> £M 2 ☐ F	7	9 <sup>Y</sup>	rs.	la buy	3 110013		Feb. 1				nsylv	
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ore or	1 Rurial 2 Cremation 3 Removal from State cemetery, crematory									lace)	July	Date 28,	20c. Lo	ocation -	City or 1	Town, State	
Ĕ	Pag In the pag	4 Donation 5 Other (Specify)  Metropolitan Crematory 2006 Alexandria,  21. Signature of Funeral Service Licensee  Prancis J. Coffins Funeral Home Inc.										Virg	inia				
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	Dhysisian		Immediate Cause (F	inat		_	~									Onset an	d Death
1	Physician /Medical		disease or condition resulting in death)		u	creati			·					<u>-</u>		3 Mo:	nths
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30.	be executed sicien and burial-transit	E			Duo to	(01 43 4 00115	soquorice or	,.									
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9	th certific ending p	Me	tF FEMALE:														
Вох	ath co	an	23b. Was decedent p in the past 12 m		23c. tf yes, or 1□Live	itcome of pred birth 2 □ F		3 □Ectopi	c pregnar	ncy				23d. Date Mor		very Day	Year
	dea ded fo	Sici	1 Yes 2		4∏Preg 9∏Unki	nant at time o	of death	5 🗌 Other	(specify)					IVIOI	101	Day	T Bal
D. 0	ires that the death certificate be executed signed by the attending physicien and be detached for use as the burial-transit	Physician/Medical	9 🗆 Unknown														
S	es that igned t	by	Part II. Other signific	ant conditions	contributing to	death but not	resulting in t	he underlyir	g cause (	given in Part	1.					the cause o	
70		<b>1</b> 0										1 🗆	Yes 2	No	3 ☐ Pro	bably 4 [	Unknown
S	The law requive hes been bage 2 should	Complete										24a. Wa	s an	24b. V	Vere aut	topsy finding ompletion of	s available
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ion of Vital Recor	en: T tificet tor, pe	e C	25. Was case referre	ed to medical	1					00.00	4 5 : :			1	∟ Yes	2 No	
S	Physician: this certific ral director,	<b>m</b>	examiner?		Hospital:		OFF?					h (Check only			4.5		
of	Phys this rat di	ဥ	27. Manner of Death		1			atient 3	DUA In	4 L N		me 5€ Res				iry)	
2	nding lath. r: After e funer	ation:	1 🔀 Natural	5 Pending		of tnjury oth, Day Year	) 280. III	ury	28c. In W	ork?		ZOU. DOSCIDO	now injui	y occurr	ad.		
. <u></u>	e :: # G	ä	2 Accident	investigation	on			M	1	Yes 2	TINO						

Bruwelheide

1. Decedent's Name (First, Middle, Last)

W.

4a. Facility Name (If not institution, give street and number)

Fred

Physician

/Medical

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ed? ☑ No nce 6 Other (Specify) w injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) July 28, 2006 d cause of death (Item 23a) (Type, Print) 5454 Wisconsin Avenue, Chevy Chase, MD 20815

State Registrar

Certificat

3 🗌 Suicide

29a. Certifier (Check only one)

4 🔲 Homicide

29b. Signature and title of certifier

30. Name and address of person who comp Frederick Barr, M.D

6 Could not be determined

1211

29c. License number

D22775

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No.

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 2 No

1129 M

2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** BURNSIDE 2006 **GENEVA** 30 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11-22-1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 76 215-24-0488 MARYLAND Director Usual Residence of Decedent 10a, State 10c. City, Town or Location ir then "natural", or iteme 23e or 28e-f ehov the Medical Examiner must be notified at SUSSEX DELAWARE SELBYVILLE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 19975 246 W. BLUEWATER RUN nit. Peges 1 and 2 should be filed within 72 hours after dee sarinent of Heelih and Mental Hygiene. ootent: If item 27 is marked other than "natural; or iteme injury or other traumatic event, its Medical Examinatin 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) DENTAL HYGIENIST DENTISTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KATHERINE **SWEETING** WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA REMINGTON/ DAUGHTER 668 CARRIAGE PARKWAY, FT. COLLINS, COLORADO 80524 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State LOUDON Crematory or other place) 1 

Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MARYLAND 8-3-06 permit. F Departme Importar any injur **Physician** /Medical Examiner

Box 68760,

Division of Vital Records, P.O.

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physicien and s the buriel-transit To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Al completely filled in by the fu

1 15 146	WE	ST AVE., OCEAN	VIEW, DE., 1	9970
shock, or heart failure. List only one	ations that caused the death. Do not enter cause on each line.	, , , , -		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	commany a	very discase		Oligot and Douli
Tooling in doubly	Due to (or as a consequence of):  URO SEPSIS	V		1
Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
cause. Enter Underlying Cause (Disease or injury that initiated events	PNEUMONI	14		
resulting in death) Last	Due to (or as a consequence of):			
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions contr	ributing to death but not resulting in the und	derlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical examiner?	A		eath (Check only one)	
1 ☐ Yes 2 No	spital: 1 Inpatient 2 ER/Outpatient	3□ DOA Other: 4□ Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how inju	
3 Suicide 6 Could not be	28e. Ptace of Injury - At home, farm, stre- building, etc. (Specify)	et, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,

State Registrar

o completed cause of death (Item 23a) (Type, Print)

046536 07/3 Salisbury MD 21801

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3 Time of Death Day 2006 Month Year **Physician** 11:10 a M Thomas Benjamin Bailey, III 29, July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **№** М 2 Б Yrs Director 219-34-8684 68 2, 1937 Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or frems 23a or 28a-f ehow tre Medical Examinar must be notified at 1 ☐ Yes 2 ▼ No Maryland Prince George's Lanham Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6716 Cathedral Avenue 20706 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give 1957-63 Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No SpecifyWhite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Facilities Specialist Government Contractor filed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be me Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic ever once. Be Thomas Benjamin Bailey, Jr. Frances Clothier Hynson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Louise Bailey/ Wife 6716 Cathedral Avenue, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 3, 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2006 Suitland, Maryland 21. Signature of Funeral Service Licensee francis Adress Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 censo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician Metabolic Midos /Medical Due to (or as a consequence of) Examiner Bowe mall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physicien and s the burial-transit The law requires that the death certificate be executed Cance don Due to (or as a consequence of): Box 68760. Physician/Medical 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) O 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 22 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 A patient Certification; To 1 Yes 2√No 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Alaturaf 5 Pending 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu death. investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2() Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 1401 30. Name and addr of person who completed cause of death (ftem 23a) (Type, Print) ACEC EMA 2108 DIDonato Drive LEYNALDO LEE-LC 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006

Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryl		tificate of			Reg. No.	06 2	5660
1	Physici /Medic		1. Decedent's Name (First, Middle, La George A. Cande	,				2. Date of De Month JULY	Day	Year ,	Time of Death  0:05AA
	Examir		4a Facility Name (If not institution, give	re street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
			FutureCare Che				Arnolo			Arunde	
	Funeral Director		5. Social Security Number 6. S 033–16–7005 Usual Residence of Decedent	TVIM OF E	78 Yrs.	If Under 1 Year Months Days		(Month, Da	th y, Year) 2, 1928	9. Birthplace Country)	(State or Foreign
	lend w		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. l	Inside City Limits
	Mary	to	MD Anne A	Arundel		Pasader	na			1	1 ☐ Yes 22€ No
	or 28	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?	
	th wil	al D	108 Charlinay	Circle			21122			USA	
21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examera	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub ☐ Yes 2 XNo	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	e - American Ir ck, White, etc. v: Whit	
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	ent's Usual Occup	pation during most of work d)	ing	16b. Kind of Bu	usiness/Industr	у
21	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)					NIST	_	
12	led w lygier her th	Co	47 Fall of Name (First Middle Land	5+	Pr	ysical (	Inemist 18. Mother's Nam	o (First Middle			ernment
anc	ntal H	Be	17. Father's Name (First, Middle, Last Michelangelo Ca				Disma A		, Walderi Sulliani	10)	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic event, the Men	To	19a. Informant's Name/Relationship (		19h Mailin	n Address (Street	and Number or Rui		er. City or Town.	State. Zip Con	
	nd 2 s Ith an 27 is i		Jane Candela/W				y Circle,		-	21122	-,
ē,	s 1 and 2 f Health tem 27 i		20a. Method of Disposition		b. Place of Dispo			Date	20c. Location -		State
9	Pages nent of h unt: if ite ury or of		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		114	rematory	1	Jul. 26, 2006	Baltin	more, M	D
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any Injury or other ti once.		21. Signature of Funeral Service Cice	/ /	, ) E	Name and Addre	& Sons, F Ritchie	.A. Sev	erna Par	k Fune:	ral Home 21146
	Physician		23a Partt. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	leath. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	App	proximate erval Between set and Death
	/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in th)	a. META.  Due t	STATI to (or as a conseq		ING C	ARCIN	onA		
	ificate be executed g physician and as the buriel-transit	Exar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conseq	uence of):				į	
68760,	e be e	edicai	that initiated events	C. Due to	o (or as a consequ	uence of):					
Box 68	- D 0		resulting in death) Last	d	(**************************************						100
	death e atte	sicia	Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderlying cause gi	ven in Part I.	23b. Did	tobacco use cor	ntribute to the	cause of death?
S, P.O	res that the designed by the a	by Physician/M	SYNDROME OF 1	NAPPROPRI	47E 41	VTIDIUR	ETIC HOR	none 10	Yes 2□ No	3 Probably	y 4 ☐ Unknown
Records,	requi	Completed t						24a. Was perfo	an autopsy ormed?	availab	autopsy findings de prior to stion of cause h?
Re	he law e has age 2	E						101	Vec 1000	1 ☐ Ye	s 2 No
Vital		Be C	25. Was case referred to medical				26. Place of Deat	h (Check only o		1	
<b>f</b> <	Physicien: rthis certific rral director,	To E	examiner? 1 ☐ Yes 2☐No	Hospital:	2 ER/Outpatien	t 3 DOA Oti	her: 4 Nursing Ho	ome 5□Resi	dence 6 □Oth	er (Specify)	
u of	g Ph ter th		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Inju Wo	ry at	28d. Describe	how injury occur	red	
Sio	Attending or death.	atic	2□ Accident investigatio	n		M 1□	Yes 2□No				
Division	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp		eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural Ro	ute Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		nyeician: To the best of my l niner: On the basis of exam and manner stated.		estigation, in my	opinion, death occur				
<u> </u>	To th	Σ	29b. Signature and title of certifier	ms		D 5	56 number 7 5 3 1		7uly 2		•
			30. Name and address of erson who	completed cause of death (	Item 23a) (Type,	Print)	xsville				
	Sta	te	Mohit Nag 8 31. Date filed (Month, Day, Jear) JUL 3 1 2	32 degistrar's Si	ignature	1	7001012	, ,,,,			
	Registr		JUL 3 1 2	2006	N A	selle.					
DH	MH 16 Rev 6/9	5			7			-			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician July 30, 2006 08:30 PM Delores E. Cessna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg 200 McCulloh Street If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 👿 F Yrs. Director 214-36-6674 16-Feb-1937 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Iteme 23s or 28s-f show ury or other traumatic svent, the Mudical Examinat mink for multiled at 10a. State 10b. County 1 Yes 2 □ No Director Maryland Frostburg Allegany 10e. Street and Number 200 McCulloh Street 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) sales clerk retail store 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Godfrev Stott Dorothy McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra-200 McCulloh Street Herbert Cessna 21532 Husband Frostburg Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-Aug-2006 Cumberland Maryland Cumberland Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 olen 7 Ba. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION **Physician** GIVE HOUR /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physician and use as the burial-transit death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ REWAL FALLURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No DIABUTES 24a. Was an page 2 autopsy 1 Yes the Hospital or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) • Euneral Di • Funeral Di letely filled in Techtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 033417 (MANYUNO) JULY 31, 20:6 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) かんら N-MUEW, M.D mues WATIONAL HIGHWAY LAVALE MANTEMA 21502 1063 3 Registrar's Signature 31. Date filed (Month Date AUG 0 1 2006 State Registrar

					State of Maryland / Department of Health and Mental Hyg	iene	
				1 - For State Registrar	Contificate of Dooth	ag. No. 0 (16	25663
	8-	Physici		1. Decedent's Name (First, Middle, Las	2. Date of Death Month	Day 2(Year	3. Time of Death
		/Medic Examir		4a. Facility Name (If not institution, give		4c. County of Deat	h
		Funeral	40	5. Social Security Number 6. Se	x 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min.   (Month, Day,	20 mer	SCT hplace (State or Foreign
		Funeral Director		075-28-0250 1	Yrs. Months Days Hours Min. 2 Month, Day, 2 -27 -	Year) Co	hplace (State or Foreign untry)  UA
		ow ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
7		72 hours after death with the Maryland naturel", or items 23a or 26e-f show deat Ezaminer must be notified at	ector	Md. Worce	ster Pocomoke		1 Yes 2 No
Di		h with t	Funeral Director	10e. Street and Number	rept 2/85/	0g. Citizen of What Co	untry?
2		er dea items	uner	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Ame Black, White	
1:1	5-0036	ours aft	by	3 Widowed 4 Divorced	1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Year or Dates:	Specify: R	lack
7			Completed	15. Decedent's Edi (Specify only highest grad	ication 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired),	16b. Kind of Business/	Industry Trucking
۲)	2121	be filed within ital Hygiene. Id other then "event, the Me	omo	Elementary/Secondary (0-12)	College (1-40r 5+) Truck-driver	Jackiel	Hadding
3	pur	d ia b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, A	faiden Sumame)	
5	Maryland	2 should and Menis Is marke	2	HIDEF+  19a. Informant's Name/Relationship (T)	CUSTIS Leila Cr	City of Town, State, Z	lip Code)
7		nd 2 lith a 27 is		Christine Richar	dsow (daughter 8641 Jersey Rd. Salisbu	rymd, 2	1801
27	Jore			20a. Method of Disposition  1 Burial 2 Cremation 3 1	Removal from State cemetery, crematory or other place)	20c/Location - City or	Town, State
<u>&gt;</u>	altimore,	그 문문을		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License	Total Car Cent D = 00	emperas	ceville, VA.
13	Ä	Depa Impo eny is		Muscula	Knineld P.O. Box 331 Pocomol		md. 21851
1)				23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	AT COMPANY CONTRACTOR	ıst,	Approximate Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):		5 years
	4-4-4-4	Examiner			b		5 years
		uted d ansit	Examiner	it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Oue to (or as a consequence of).		
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0.1	XO	eath certific attending p for use as	an/Me	230. was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	23d. Date of deli	-,
96	Ю. В	the d	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify)	Month	Day Year
0	s, P.	ires thet the signed by d be detact	by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob	acco use contribute to	the cause of death?
$\mathcal{O}$		requir	eted				obably 4 Unknown
ames	Vital Record	ding Physician: The law requir h. After this certificate has been si funeral director, page 2 should	Completed		24a. Was ar autops; perform	y prior to o death?	topsy findings available completion of cause of
E	ital	ortifical	BeC	25. Was case referred to medical examiner?	1 ☐ Yes 2 26. Place of Death (Check only one		2 □ No
1	of V	Physic r this corral dire	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe ho		arty)
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	Division	- i e -	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Str. City or Town.	reet and Number or Ru , State)	ral Route Number,
		To the Hospital or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death occurred at the time, date and place, and due to the ca	use(s) and manner as	stated.
		the Ho hin 24 the Fu npletel	Medicai	(Check only 2   Medical Exam	ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, da and manner stated.	ate and place, and due	to the cause(s)
		To To	-	29b. Signature and title of certifier		ed. Date signed (Month	n, Day, Year)
	V ~				DR-USHA NATESAW Do 573 59 ompleted cause of death (Item 23a) (Type, Print)	01170170	
	BF			31. Date filed (Morith, Day, Year)		04	
		Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2 20	06 there It freds		

	1 - For State Registrar	-	Department of Health and Certificate of Death	Mental Hygien Reg. N	2000 20004
	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month D	ay Year 3. Time of Death
Physician	Melody Penny	/ Custer		August 1	2006 10:20PM M
/Medical Examiner	4. English blame //f and institution aire of		4b. City, Town, or Location of Deat		c. County of Death
Examiner	Avalon Manor Nursi	ing Home	Hagerstown		Washington
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birt.			Birthplace (State or Foreign
Director	174-44-3093	M 2DXF 54	rs. Months Bays		952 Pennsylvania
2	Usual Residence of Decedent	10c. City, Town	or Location		10d. Inside City Limits
nylar show	10a. State 10b. County				1 ☐ Yes 2 ☒ No
Be-f.	Maryland Washingt	con C	lear Spring	1	
vith the Mar or 28e-f sl be notified	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
ath w			21722		U.S.A. 14. Race - American Indian,
riter death viritems 23s	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
irs afte	1 Never Married 21 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔼 No If Yes, Give	1 ☐ Yes 2X No Specify:		Specify: White
hours ural		Year or Dates:	Decedent's Usual Occupation	16h	Kind of Business/Industry
ed within 72 horygiene. Per then "naturality, the Maulcality,	15. Decedent's Education (Specify only highest grade)	completed)	(Give kind of work done during most of wo life. DO NOT use retired)	rking	, , , , , , , , , , , , , , , , , , , ,
d withir	Elementary/Secondary (0-12)	College (1-4or 5+)	Clerk		Retail Sales
filed within 72 hours after death with the Maryland Hygiene.  Other then "natural; or Items 23s or 28e-f show out, the Modical Examiner must be natified at a Commission by Filmers Director			18. Mother's Na	me (First, Middle, Maide	en Sumame)
weld be fill Mental Hy arked oth atic even	i		NI ma	Colo Willow	
hould d Men marke matic	Hesker Horne  19a. Informant's Name/Relationship (Typ	e. Print) 19b.	Mailing Address (Street and Number or R	Gale Miller ural Route Number, City	
d 2 st th and th and t7 is r traur			75		g Maryland 21722
Heali ther	H. Ray Custer, Jr.	20b. Place of	Disposition (Name of		Location - City or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or liems 23a or 28e-f show any righty or other traumatic event, the Madical Examiner must be nutified at once.  To Be Commissed by Firneral Director	1 ☐ Burial 2X Cremation 3 ☐ Re	moval from State Smith	y, crematory or other place) sburg Crematory 8-4	4-2006 Sm	ithsburg Maryland
t. P.	*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses				Fiery Fuenral Home
Definit. Pages Department of importent: If it any injury or o	21. Shinature of Punetal Service Licenses	7.			_
402.00	Mugas A.	ations that caused the death. Do r			town Maryland 21742
		cause on each line.	not enter the mode of dying, such as cardia	to or respiratory arrost,	Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition	Hunt	iglan's choice		7
/Medical Examiner	resulting in death)	Due to (or as a consequence	of):		
	Sequentially list conditions, b.		-A.		
p iii	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	51).		
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death certifi e attending I	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetel death			Month Day Year
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sician: The law requires to certificate has been significated by the certificate has been significated.				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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Physician: The this certificate ral director, pag	25. Was case referred to medical examiner?			eath (Check only one)	
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I or Attending after death. Director: After in by the fune	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
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in 10 in 11	29a. Certifier 1 Certifying Phys		e, death occurred at the time, date and plac d/or investigation, in my opinion, death occ		
To the Hos within 24 h To the Fun completely	29b. Signature and title of certifier	And manifer stated.	29c. License number	29d. I	Date signed (Month, Day, Year)
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					,
54-11	30. Name and address of person who co		MILL ST MAL!	ERSTOWN	MD 21740
3H-4 State	at Day Clad (Marth Day Your)	32. Registrar's Signature			
State Registra			1. 1.		

	1	For State Registrar	State	of Maryl	and / Dep <i>Ce</i>	artmer			and M	lental H	lygien	/ 111	)6	25	665
		1. Decedent's Name (First, Middle,	Last)							2. Date of Month	Death D	ay	Year	3. Time o	of Death
Physiciar /Medica	_	RAYMOND COOPE	RSTEIN							JULY		2006		12:0	0 P <sup>M</sup>
Examine	•	4a. Facility Name (If not institution,	give street and n	umber)		4b. City	, Town, or	Location of			4	c. County o			
		SUBURBAN HOSP						BETH						CGOMER	
Funeral	- 1	, , , , , , , , , , , , , , , , , , , ,	6. Sex 1 🔀 M 2 🗆 F	7. Age (In )	yrs. last birthday 81 Yrs.	Months Months	r 1 Year Days	If Under:	Min	8. Date of (Month,	Dav. Yea	(1)	Cour	lace (State	or Foreign
Director		068-12-3464 Usual Residence of Decedent			115.					NOV.	19, 1	1924	NEW	YORK	
and and	-	10a. State 10b. County	<del></del>	10c.	. City, Town or L	ocation							1	Od. Inside C	City Limits
Mary i	,	MARYLAND M	ONTGOMER	v		POTO	MAC							1 ₹Yes	s 2 □ No
28a	2	10e. Street and Number	ONTOOLIDI	(1			p Code				10g. C	Citizen of W	hat Cour	ntry?	
3a or	5	10935 DEBORAH DR	RIVE					20	854			ι	J.S.	A.	
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23e or 28e-f show event, the Madical Examinar must be inclified at	2	11. Marital Status	12. Was De	cedent Ever i	in U.S. 13	Was Dece	edent of Hi	spanic Ori	gin? (Spe	ecify Yes or Rican, etc.)	No-			can Indian,	
after or Its	2	1 Never Married 2 Marrie		Forces? s 2 ☐ No W	WII	1 ☐ Yes		Specify:	i, Puerto	nican, ec.,			, White,	WHITE	7.
rai',	n D	3 XWidowed 4 ☐ Divorced	Year or	Dates:		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2123.140	Specify.				Specify:			
72 h	Completed	15, Decedent' (Specify only highest		al)	(Giv	edent's Usi e kind of w	ork done d	during most	t of work	ing	16b.	Kind of Bus	iness/in	dustry	
hen hen	Ē	Elementary/Secondary (0-12)	College	(1-4or 5+)	//re.	NUCLE		•	т			DEDAE	ידאיני	NT OF	ENERG
lled v tygie her t	3	17. Father's Name (First, Middle, L		5+		MOCTI	AK C.			e (First, Mia	dle Maide				DIVERS
t be fi	a	ISAAC COOPERSTEI								HIPKI		on ourname	,		
2 should and Men is marke raumatic	0	19a. Informant's Name/Relationsh			10h Mai	ling Address	s (Street a			al Route Nu		Or Town 9	State Zir	Codel	
d 2 sl th an 7 is r traur		ANDREA E. COOPER		AUGHTER		WEST	COUN	T ROA	D 50	, BEL	LVUE	COLC	RAD	0 8051	.2
1 and Health em 27 Ither tr	0.0	20a. Method of Disposition			b. Place of Disp	osition (Na	ame of	1	(	Date	20c.	Location - (	City or To	own, State	-
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Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. LUNG Due t	CANCER	sequence of):									Onset and	Death AR
nte be nysicia ne bur	Icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due t	o (or as a con	sequence of):										
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the death ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of presented birth 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Fetal death 3	□Ectopic   □ Other (s					-	23d. Date Mon		ery Day	Year
that	by P	Part II. Other significant conditio	ns contributing to	death but not	resulting in the	underlying	cause give	en in Part I.		23e. D	id tobacco	o use contri	bute to t	he cause of	death?
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he la e has age 2	E									p	utopsy erformed?	? de	nor to co eath? □ Yes	mpletion of	cause of
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Fla	ce of Injury - i	At home, farm, soecify)	treet, facto	ry, office				n (Street Town, Sta		r or Rura	al Route Nu	mber,
he Hospit n 24 hour he Funera pletely filli	edical	29a. Certifier 1 X Certifyin (Check only 2 Medical I	g Physician: To t Examiner: On the and ma	the best of my basis of exar anner stated.	knowledge, de mination and/or	th occurre nvestigatio	d at the timen, in my op	ne, date an pinion, dea	nd place, ath occur	and due to red at the tir	the cause ne, date a	(s) and mar and place, a	ner as s	tated. the cause	(s)
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		30. Name and address of person						(1787 T T	ים ד	MADTT	A NTD	20050			
		DR. JAMES BROWN			CENTER	חאדאן	E, KU	CKATT	ч. Т. ,	MAKYL	AND A	4U03U			
Stat Registra		31. Date filed (Month, Day, Year)  AUG 0 1	2006	Registrar's S	Signature	acte									

	•	For State Registrar		aryland / Depa Cei		lealth and	Mental Hyg	_	25665
Physicia /Medic Examin	in al	4a. Facility Name (If not institution, give	street and number)	Connor	4b. City, Town, or		2. Date of Dea Month July 2	Day Year	3. Time of Death 4:05 P M
Funeral Director		10104 Green Fores 5. Social Security Number 264 28 0485  Usuel Residence of Decedent		e (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min	. (Month, Day		Georges rthplace (State or Foreign ountry)  1abama
the Maryland 28a-f ehow colling at	_	10a. State 10b. County  Maryland Prince G  10e. Street and Number	eorges	10c. City, Town or Lo	10f. Zip Code			10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2≰ No
ter death with teme 23a or irer must be r	Funeral Dir	10104 Green Forest  11. Marital Status  1 Never Married *** Married	12. Was Decedent Armed Forces?	lo l	2078 Was Decedent of H If Yes, specify Cuba			USA	erican Indian,
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 Ie marked other then "natural", or iteme 23e or 28e-1 ehow eny Injury of other traumatic event, the Medical Examination at another and injury.	Completed by F	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	If Yes, GiveXX Year or Dates:	16a. Dece (Give	1 ☐ Yes ♣ No  dent's Usual Occup kind of work done of DO NOT use retired	ation during most of w	orking	Specify: Wh	s/industry
fand 212	To Be Com	17. Father's Name (First, Middle, Last)  Edward Tison	2	Off	ice Manag	18. Mother's Na	me (First, Middle,  Meeker	Law Fir	<b></b>
re, Mary s 1 and 2 shou f Health and M ltem 27 le mai		19a. Informant's Name/Relationship (7  Thomas H. Connor  20a. Method of Disposition	/ Husband		Green F	orest Di		r, City or Town, State, phi, Maryl 20c. Location - City o	and 20783
Baltimore, permit. Peges 1 a Department of Her Important: If Nem eny Injury of othe		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify  21. Signature of Funer   Silver   Cen	7 0	Parklawn 25	Memorial  Name and Addre	Park 7	ines Rina	Rockville, ldi Funera lver Sprin	
Medical  Wedical  Washington and  washington and  washington  wash	ical Examiner	2da. Part1. Enter the disease, or competence, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as PRIMA  Due to (or as C.	Ithe death. Do not enter.  IC FAILURE a consequence of):  RY BILIARY a consequence of): a consequence of):			ac or respiratory an	rest,	Approximate Interval Between Onset and Death
, P.O. Box 687 thet the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy	′		23d. Date of de Month	elivery Day Year
<b>0</b> 8 5 8	Ď	Part II. Dther significant conditions of E. COLI BACT		ut not resulting in the u	inderlying cause giv	en in Part I.	-	obacco use contribute	to the cause of death?  Probably 4 Munknown
	e Completed	25. Was case referred to medical				26 Place of D	24a. Was autop perfor 1 Yes	sy rmed? prior to death? 2 ■ No 1 □ Ye	autopsy findings available completion of cause of s 2 No
Division of Vital Record Hospital or Attending Physician: The law requir 94 hours after death. Funarel Director: After this certificate has been si tely filled in by the funeral director, page 2 should	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be		ry 28b. Time o	f 28c. Injur Wor M 1	ler: 4 ☐ Nursing	Home 5 Resid	lence 6 ☐ Other (Sp low injury occurred	
pplta ours ours inlec		4  Homicide determined  29a. Certifler (Check only 2  Medical Exam	building, et	of my knowledge, deat	h occurred at the tir		City or Tow	m, State) cause(s) and manner a	as stated.
To the Hoe within 24 h. To the Fun completely	Medical	29b. Signature and title of confider  29b. Name and address of person who	by M	ated.	29c. Licens			July 3	
Sta Registi		NORTON ELSON, M. 31. Date filed (Month, Day, Year)	D., 7600		ENUE, TAK	COMA PAR	K, MARYLA	ND 20912	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#/, perFH, G838, 8/25/00, WS
State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

		•	For State Registrar	State of Ma	irytanu	Cei	rtificate	of L	Death	and wich		Reg. No.	2000	25	00/
			Decedent's Name (First, Middle, Las	t)						2.	Date of Dea	ath Day	Year	3. Time of	Death
	Physicia /Medic		Vernon Leroy Cl	nurch						J	uly 29		006	4:33	A. M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or	Location o	f Death		4c.	County of Deatl	1	
			12471 Algonquin T				Lusby	<u> </u>					lvert		
	Funeral Director		577-64-0595	9x 7. Age M 2□F	(In yrs. las	st birthday) Yrs.	If Under 1 Months	Year Days	If Under : Hours	Min.	Date of Birt (Month, Day ept. 5	v, Year)	Co	nplace (State of untry) ington	
	pu s		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	ocation							10d. Inside Ci	ity Limits
	Aaryis I sho	ō	Maryland Calvert		Lush	NZ.								1 🗆 Yes	∑ No
	28a-	Director	10e. Street and Number		Парк	'Y	10f. Zip C	Code				10g. Citi	zen of What Co	untry?	
	3a or	Ö	12471 Algonquin T	rail			206	57			1	Unit	ed Stat	es	
	death ms 2	Funerai	11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes 2 N	ver in U.S.	. 13.	Was Decede		spanic Orig	gin? (Specif			14. Race - Ame Black, White	rican Indian,	
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, it a Madical Examinan wast be motified at	by	1 ☐ Never Married	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0		1 ☐ Yes 2	_	Specify:	, r dono riic	Jan, 010.7			hite	
	72 ho	eted	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usual kind of work DO NOT use	Occupa done d	ation during most	t of working		16b. Ki	nd of Business/	Industry	
1	be filed within 72 h ital Hygiene. id other than "natu event, It e Medical	Completed	8Enmentary/Secondary (0-12)	College (1-4or 5	+)		<i>DO NOT</i> use P <b>orter</b>	retired,	)	-		λıı+	omobile	Doalo	cchin
7	2 should be filed within and Mental Hygiene. is marked other than aumatic event, If a M.		17. Father's Name (First, Middle, Last)			Cai r	Orcer		18 Mothe	r's Name /F	First, Middle,			Deate	гэнтр
2	ntal h	Be	William S. Church							·	Worre				
	should nd Men marke umatic	<sup>2</sup>	19a. Informant's Name/Relationship (			19b. Mailir	no Address (	Street a					r Town, State, Z	(ip Code)	
<u> </u>	d 2 s th an th an trau		Mary McKinney Chu										yland 2		
ם מ	s 1 and 2 should f Health and Men item 27 is marke other traumatic		20a. Method of Disposition		20b. Pla	ce of Dispo	osition (Name	e of	-	Date			cation - City or		
	Page nent o ant: If ury or		1 XBurial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	y)		sapea	ke Hig	hla	nds 8	3/02/2			t Repub		rylan
0	permit. Departr Importa any inji		21. Signature of Funeral Service Licer	1500									l Home, lic, Mary		76
			23a. Part1. Enter the disease, or com	plications that caused	the death.								iic, reily	Approximat	0
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A Due to (or as	08	1860 ence of):	Onc		ARL	) (DCF	ASCU	M	DISER	Interval Bet Onset and	Death C
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):									
	rtificate be executed ng physician and i as the burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as	conseque	ence of):									
0000	siciar siciar b buri	Sai	(	d											
000	tificate ng phy as the	Medicai													
O. DOX	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal o	death 3[	□Ectopic pre □ Other (spe					2	23d. Date <i>o</i> f deli Month	-	Year
ŗ	res that igned by be deta		Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	underlying ca	use give	en in Part I.		23e. Did to	obacco u	se contribute to	the cause of c	leath?
Spics	quires n sigr ald be	d by									10	res 21	□No 3 Pr	obably 4 □l	Jnknown
	Physician: The law require this certificate has been si ral director, page 2 should 1	Completed										sy rmed?	prior to death?	topsy findings completion of c	available ause of
VIEGI		ပိ	25. Was case referred to medical		-				26. Place	of Death (	1 ☐ Yes Check only o		1 □ Yes	2 140	
	Physician: r this certific ral director,	0 8	examiner? 1 <b>X</b> Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 E	R/Outpatie	nt 3 DO	A Othe					6 □Other (Spec	cify)	
5		T:u	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	y Year)	28b. Time o	of 28	Bc. Injun	/ at		d. Describe I				
	andin ath. or: Af	atic	2 Accident investigatio	n			М	1 🗆 1	Yes 2 🗆						
DIVIS	al or Attending s after death. Il Director: Afte id in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined				reet, factory,	office		28	f. Location (S City or Tov	Street an vn, State	d Number or Ru )	ıral Route Num	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edicai (		nysician: To the best of miner: On the basis of and manner sta	examination										5)
	within To th comp	Me	29b. Signature and title of certifier				100		e number	31		29d. Dat	e signed (Monti	h, Day, Year)	
			111.0		~		$ \mathcal{D} $		185	77		JUL	4 31	ZO	06
	15		30. Name and address of person who Philip Wisotsky,					Sui	te 20	)7, Wa	ldorf	, Mai	ryland 2	20602	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	s Signatu	J.	Spar	de							

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death 06-05366 William Stephen Cropper, IV 2006 25658 1- For State

	F	Registrar			runcate	: 01	Dealii					Reg. No	). La 5	0 5000
Physicia Medical Exami	ın/	Decedent's Name (First, Middle									Date of De Month July 23, 2	Day	Year	3. Time of Death 1225 hrs
		4a. Facility Name (if not institution	HEN CROPP			14	b. City, Tov	vn or Lo	ocation of		outy 20, 2		tc. County of Death	
		Atlantic General Hospi	· <del>-</del>	arriber)			Berlin	m, or 2.					Worcester	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	y)	If Under	1 Year	If Under	r 24Hrs.	8. Date of B	irth (MN		hplace (State or
Director		001 76 (101	1 TM 2 TF	٠,		Vro	Months	Days	Hours	Min	0 ( 1		Foreig	n untr <del>vivasse</del> Assa sass
	L	221-76-4131	1 M 2 F	24		Yrs.					9-6-1	1981		DELAWARE
ану	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or L	ocatio	on							10d Inside City Limits
* 3		Toa. State		100. 010	y, 10111101 E	obdiic								1 Yes 2 <b>X</b> No
Aaryland 28a-f show 1 at once.	햙	DELAWARE SUS	SSEX	FF	RANKFO	RD								
daryl 28a-	ect	10e. Street and Number					10f. Zip Co	ode				10g. Ci	itizen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once	Dire	RT 2, BOX 133E						19	945			UNI	TED STAT	ES
with as 23	ᅙ	11. Marital Status		cedent Ever in	U.S. 13						cify Yes or N		14 Race - Ameri	
eath item	Fune	1 Never Married 2 Ma	Armed F	2 X No		IT YE	s, specify (	Juban, I	wexican,	Puerto Ri	ican, etc.)		White, etc.	
fter d		3 Widowed 4 Dive	orced If Yes, Give Ye	ar	1		Yes 2	No	specify:				Specify: WH]	TE
hours afte 'uatural'', Examiner	호	15. Decedent's Education (Spec		ade completed)			's Usual Oc					16b.	Kind of 8usiness/I	ndustry
2 ho	ompleted	Elementary/Secondary (0-12)	College (	1-4 or 5+)	<b>d</b> urir	ng mo	st of working	ng life. [	DO NOT I	use retired	d)			
5-0036 led within 72 Hygiene other than the Medical	힐	12			APPR	ENT	CICE E	T.E.C	TRIC	TAN		ET	ECTRICAL	CONTRACTOR
-003 I withi giene ther the	5	17. Father's Name (First, Middle,	Last)								First, Middle		n Surname)	
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	Be C	WILLIAM S. CRO	ODDED TIT						TERE	GA D	. EVAI	NG.		
	B	19a. Informant's Name/Relations			19b. M	ailing	Address						City or Town, State	. Zip Code)
Shou shou and haric	+			IED	- 1	_		,					19945	, ,
MD and 2 sho eath and 2 is em 27 is raumat	ŀ	TERESA D. CROPI  20a Method of Disposition	rek/ HUID		. Place of Di						Date		. Location - City or	Town, State
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental taut: If item 27 is marked or other traumatic event,		1 Burial 2 Chemation	3 Removal t	from State	crematory of the cremat	or oth	er place)		-					
Page nent ant: or ot		Donation 5 Other Sc	pecify:		EMATO		) F EN			7-29	-2006	FF	RANKFORD,	DELAWARE _
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic		21 Signature of Juneral Sec	nsee			22. N	ame and A				TORC 1	T TOTAL		
<b>a</b> 82 <b>a</b> 1		1/1/2/21	West			Ш	TCHE	ST	KAL	RANK	ICES I	DE.	19945	
Physician		23a Part I. Enter the d' e se, or failure. List only ne cause		caused the dea	th. Do not en	ter th	e mode of	dying, s	uch as ca	ardiac or r	espiratory a	rrest, sl	hock, or heart	Approximate Interval Between Onset and
/Medical	0 1	Immediate Cause (Fir al disease	Casain	e intoxic	ation									Death
xaminer		or condition resulting in death)		a consequence										
-1	- 1	Sequentially list conditions,	b.											
	ě	if any, leading to immediate	Due to (or as	a consequence	of):									
	힐	cause. Enter Underlying Cause (Disease or injury that initiated	C		-f):			_				_		
ed sit	Examine	events resulting in death) Last	,	a consequence	or):									
760, cate be executed physician and the burial - transi			1									-		-
760, icate be est physician the burial	an/Medical	WUNPENDED	AMENDED	item#23	a,27,28	a-f	,perÆ	,g858	3,8/19	9/06 T	T			
76( icate physthe p	Ž	IF FEMALE: 23b. Was decedent pregnant in th		, outcome of pro		1		2	T-t			2	3d. Date of delivery	
68 certif	lan	past 12 months?	I LIVE	pintn nant at time of	death _ =	-	al death		Ectobic	pregnan	СУ		Month I	Day Year
OX Sath c	Sic	1 Yes 2 No 9 Uni	Known 9 Unk		5	Oth	ner (Specif	y)						
that the death certiff the by the attending detached for use as	Physici	Part II. Other significant condit			t resulting in	the u	nderlyina c	ause di	ven in Pa	rt I.	23e. Did	tobacc	o use contribute to	the cause of death?
that that detay		, a		10 0001111 201110				3			1 TY	es 2	No 3 Prot	pably 4 🗸 Unknown
ds, P.C	Completed by						<del></del>				24a. Wa			
rd w re s be	Set										aut	opsy	prior to d	topsy findings available completion of cause of
Rec The la icate h	Ĕ										1 🗸 Yes	formed'	? death? No 1 ✓ Ye	es 2 No
tal Recosian: The law certificate has		25 Was case referred to medica	ı T				26	.Place	of Death	(Check or	nly one)			
Vita ysicia his cer direct	o Be	examiner?	Hospital: 1	Inpatient 2	✓ ER/Outpa	atient	3 DO	A C	Other <sub>4</sub>	Nursing	Home 5	Resid	dence 6 Other	<del></del>
n of Vi ding Physi After this funeral did	-1	1 Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	28b. Tim			c. Injury	at Work	? 2	28d Describ	e how II	njury occurred	
on C ading th :: Af e fun	<u>5</u>	1 Natural 5 Pend		th, Day,Year) 7/23/2006	Fnd	11.	17	1 Y	es 2 y	No	unk			
IVISIOF or Attend after death Director:	cat	2 Accident Inves	stigation 280 Pla	ace of Injury - At			7/		- 11			(Street	t and Number or Ru	ral Route Number, City
NVI I or affer I Dir	Certification:	3 Suicide 6 X Coul	Id not be rmined (Specify		in res				ag, o				218145 Adki	
Division Hospital or Attent 24 hours after death Funeral Director:	ပိ	4 Homicide	(opean)											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page—should be detached for use as the burial—transition.	cal	(Check only one) 2 Medical Exa	hysician: To the be miner:On the basis	est of my knowl s of examination	edge, death : and/or inve	occur	red at the ti ion in my c	me, dat pinion	e and pla death oc	ace, and d curred at	lue to the ca the time. da	use(s) : te and r	and manner as star place, and due to th	ted e cause(s)
To the Hos within 24 h To the Fur	Medical		and manner	stated.										
_	Σ	29b. Signature and title of certifie	//	12					number				d. Date signed (Mo	nun, Day, Year)
		Myssa Dr	assell	MA.				O.C.N	Л. Е.			Ju	ıly 24, 2006	
		30. Name and address of person	who completed ca	use of death (It	em 23a)									,
		Melissa Brassell, MD	Assistant M	edical Exan	niner 1	11 P	enn Stre	et, Ba	altimore	e, MD 2	1201			
s	tate	31 Date filed (Month, Day, Year)		gistrar's Sign		TA:				-				
Regis		# 7 1 m d 2	2006   1	20	R	Non	0							

ORIGINAL

Thomas Christian Cline

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2006 25669

	R	egistrar			erunca	ite Oi	Deam			lor		eg. No.		Тот	me of Dooth
Physicia Medical Examin	L/A	Decedent's Name (First, Middle Thomas Christ		ıe.						_ I N	Date of Dea Month Uly 30, 2	Day	Year		me of Death 254 hrs
	4	a. Facility Name (if not institutio	on, give street and			4	b. City, Tow		cation of	f Death			ounty of D	eath	
		Frederick Memorial Ho		7 0 /	n loot birth	dov.)	Frederic		If Under	r 2/1Hrs 8	Date of Bi			Birtholac	e (State or
Funeral Director		5. Social Security Number 216-41-4131	6. Sex	7. Age (In yr	s. Iast Dirti		Months		Hours	Min	March		Fo	preign	Maryland
	L	Jsual Residence of Decedent	1 <u>A</u> M 2	12		Yrs.			L	K	laiti	20,1	774		riaryrand
any		10a. State 10b. County		10c. (	City, Town	or Location	on								Inside City Limits
and show nce.	5 1	Maryland Frede	erick		F	rede									Yes 2 No
Mary L	Director	10e. Street and Number					10f. Zip Co	ode				I0g. Citizer	n of What (	Country?	
ith the Maryland , 23a or 28a-f show : notified at once.		1000 A Heather		ive, Ap		113	2170		anic Origi	in? ( Specif	v Yes or No		ed St		ndian, Black,
ath wi		1 X Never Married 2 M	larried Armed	Forces?						Puerto Rica			White, et		
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		3 Widowed 4 Div	vorced If Yes, Give '		0	1	Yes 2	No	specify:			Sp	ecify.	Whit	e
11215-0036 Id be fifed within 72 hours after dental Hygiene. narked other than "naturat". event, the Medical Examiner	8 P	15. Decedent's Education (Spe	ecify only highest g							kind of work use retired)		16b Kını	d of Busine	ess/Indust	ry
36 in 72 h han "r	Completed	Elementary/Secondary (0-12)	College	e (1-4 or 5+)		Sti	ıdent					м-	iddle	Sch	201
d with giene	Ę.	6 17. Father's Name (First, Middle,	e, Last)	· -	<u> </u>	500	<u>racne</u>	18	3. Mother's	s Name (Fir	rst, Middle,			. ocn	301
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	8	Richard Aust	in Joy,	Jr.						n Cli					
ID 21215-003 should be filed within and Mental Hygiene. 7 is marked other the	ို	19a. Informant's Name/Relations			- 13			•		ber or Rura					
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than " or other traumatic event, the Medical.I	-	Susan Cline /	Mother	12	10 0b. Place c	000 A of Disposi	A. Hea	athe of cem	etery,	ldge I	)rive, ate	20c. Lo	deric cation - Cit	ty or Town	D 21702 n, State
ges 1 st of Ha		1 X Burial 2 Cremation		1		•	er place)			7/0/0	2006	_		, ,	
	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service			lanor		etery ame and A	ddress			200 <u>6                                   </u>				Maryland_
Balti permit Departi Import injury		Bully Sof	7			10	621 <u>0</u> 1	oss	umto	wn Pi	lke. I	rede	rick.	MD :	21702
Physician /Medical		23a. Part I Enter the dise see, or failure. Wist only one cause	r complications that e on each line.	at caused the de	eath. Do no	t enter th	e mode of	dying, s	uch as ca	ardiac or re	spiratory ar	rest, shock	c, or heart	Ap Be	proximate Interval etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		Injuries as a consequen	ce of):						-				Death
1-1		Sequentially list conditions,	b	io di comocidani	00 01).										
	iner	if any, leading to immediate cause. Enter Underlying Cause	9	as a consequen	ce of):										
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ecuted and - trans			dd				·-							-	
o, o, e be co	an/Medical	UNPENDED  IF FEMALE:	AMENDE	es, outcome of	pregnancy	_		_				23d.	Date of de	livery	
68760, certificate be nding physici	Ž.	23b. Was decedent pregnant in t past 12 months?	the 1 Liv	e birth	2	Fe	tal death	3	Ectopic	c pregnancy	/		onth	Day	Year
Box 6 ic death cer the attend	Sici		of constant	egnant at time	of death (	5 Ot	her (Specif	y)				1			
the che	Physici	Part II. Other significant condi			not resultin	g in the u	ınderlying d	ause gi	ven in Pa	art I.	23e. Did	tobacco us	se contribu	ite to the c	ause of death?
P.O.	d by										1 _ Y	es 2 🗸	No 3	Probably	4 Unknown
rds requir	lete											psy	pric	or to comp	y findings available letion of cause of
eco The fav ate has	Completed		·								1 Yes	ormed?		eth?  Yes	2 No
ian: Transcertific	Be C	25. Was case referred to medic examiner?						- 1	of Death Other	(Check only		7			
n of Vital   hing Physician: After this certif	To I	1 Yes 2 No 27 Manner of Death	Hospital: 1	Inpatient :		utpatient Time of			y at Work	Nursing F	Home 5	Residence how injur		Other:	
Division of Vital Records, rate death of Physician: The law roquir at the death of the law roquir all birectors. After this certificate has been sited in by the funeral director, page 2 should be	ion:	1 Network	nding Jul 3	lonth, Day Year) 0, 2006		8 hrs	' '		es 2 🗸	. IRi	cyclist st	ruck by	a motor	vehicle	•
rision Attentation of the control of	ficat		restigation 28e. 1	Place of Injury -	At home, f	arm, stre	et, factory,	office b	uilding, et	tc. 28	If. Location or Town,		d Number	or Rural R	toute Number, City
Division pital or Attent cours after death teral Director: filled in by the	Certification:	4 Homicide det	termined (Spec	cify) Major I						-3-	733 Old I	Middleto			on, MD
Division of Vital Records, P.C within 124 hours after dear death within 24 hours after death. To the Funeral Director: After this certificate has been signed be completely filled in by the funeral director, page 2 should be dear		29a Certifier 1 Certifying I	Physician: To the caminer:On the ba	best of my kno	wledge, de	ath occu	rred at the t	time, da opinion,	te and pla death oc	ace, and du ccurred at th	ie to the ca ne time, dat	use(s) and e and plac	manner as e, and due	s started. to the ca	use(s)
To the comp	Medical	29b. Signature and title of certif	and manr						number				ate signed		
	-	Ml. Bin	M DOLL	A				O.C.	И.E.			July :	31, 2006	6	
5		30. Name and address of person													
<b>'</b>		Melissa Brassell, MD		Medical Ex		111 8	Penn Stre	eet, B	altimor	e, MD 21	1201				
S Regis	tate trar	31 Date filed (Month All 1979)	1 2006 °	2. Registrar's Si	gnature	1	alle								
	_														

ORIGINAL

			1 - For State Registrar	State of Mary		artment of Heartificate of De			giene 20	06	25	670
			1. Decedent's Name (First, Middle, Last	)				2. Date of De		Yeer	3. Time of	
	Physicia /Medic			Olga Catter				July	30 20	006	9:45	PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo			4c. County o	f Deeth		
			9641 White Acre A			Columbia		- 5	Howa		la a a (Chanta a	
	Funeral		5. Social Security Number 6. Se	TM aFVE	yrs. last birthday) Yrs.		Hours Min.	8. Date of Bir (Month, Da 8/1/1	rh By, Year)	Coun	lace (State o	rereign
	Director		220-92-7091 Usual Residence of Decedent	65	113.			0/1/1	740	i	Peru	
6	A .		10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside Ci	ty Limits
Mon	i eh	ō	MD Howard		Columbia						1 🗌 Yes	2 <b>X</b> No
4	728a notil	Je C	10e. Street and Number		COTURDIA	10f. Zip Code			10g. Citizen of W	hat Cour	itry?	
1	30.0	O	9641 White Acre A	ot B4		21045				USA		
acop.	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, !	anic Origin? (Spe Mexican, Puerto I	cify Yes or Ne Rican, etc.)	- 14. Race Black	- Americ . White.	an Indian, etc.	
0	or its		1 ☐ Never Married 2 ☐ Marned	1 ☐ Yes ₹5 No If Yes, Give			Specify: Per				panic	
3	illed within 7.2 flours after beant with the way said Hygiene. Stherthan "natural", or Items 23s or 28s-1 show ent, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:								
5	nati	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupatio kind of work done duri DO NOT use retired)	ing most of working	ng	16b. Kind of Bus	III 622/III	dustry	
<u> </u>	than .	d d	Elementary/Secondary (0-12)	College (1-4or 5+) 5+Yrs		Physician				USDA		
V 1	Hygie ther		17. Father's Name (First, Middle, Last)				8. Mother's Name	(First, Middle	, Maiden Sumame			
	Mental Hygiene.  Mental Hygiene.  arked other that  atic event, the	o Be	Alfredo Cat	ter			Olas	Azalde	2			
	ges 1 and 2 should be filed within 72 hours after death with the wasyan to fleating and Montal Hygiene. If them 27 is marked other than "natural", or items 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at	٩	19a. Informant's Name/Relationship (T		19b. Maili	ng Address (Street and	d Number or Rura	I Route Numb	er, City or Town, S	state, Zip	Code)	
= 0	and 2.		Samantha Young/Dav	ughter	2918	Southview	Rd. Elli	icott (	city,Md.	2104	2	
<u>.</u>	f Health Item 27 other tra		20a. Method of Disposition		Ob. Place of Dispo	osition (Name of matory or other place)	D	ate	20c. Location - 0	City or To	wn, State	
2	Pages ent of nt: If it		1 ☐ Burial 2 反 Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		Metro Ci	rematory	7-31-	-2006	Catonsv	ille	, MD	
altimo	permit. Pages Department of Important: If I any injury or one		21. Signature of Funeral Service Licens	600 / M		2. Name and Address of						
מ	Depar Impo		Shew Colli	ns-Willeyla	4	112 Old Col	Lumbia P	ike Ell	licott Ci	ty,		
			23a. Part. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	death. Do not en	ter the mode of dying, s	such as cardiac o	or respiratory a	irrest,		Approximat Interval Bet	ween
e F	hysician		Immediate Cause (Final disease or condition	. metas	tatic	breast (	cancer	_		11	2 y 6	2 CVS
T .	/Medical		resulting in death)	Due to (or as a co								
ŀ	Examiner		Sequentially list conditions	b								
,	p : ii	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):							
	and and trans	Examin	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):					-		
Ď,	tate be executed thysician and the burial-transit			223 10 (0. 23 2 3								
09/80 8	physi s the l	dical		d								
و ×	ding se a:	/Me	IF FEMALE:	23c. If yes, outcome of p	regnancy				23d. Date	of delive	ery	
Š ROS	atte	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2 ☐ 4☐Pregnant at time		□Ectopic pregnancy □ Other (specify)			Mon	ith	Day 3	Year
o l	0 0 0	ysl	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown								
ت ت	The law requires that the ite has been signed by the bage 2 should be detached.	by Pt	Part II. Dther significant conditions co	ontributing to death but no	ot resulting in the	inderlying cause given	in Part I.	23e. Did	tobacco use contri	bute to t	ne cause of c	leath?
g .	n sign							1 🗆	Yes 2 No	3 Prot	ably 4 🗆	Jnknown
Hecords,	s been signature	Completed						24a. Wa		ere auto	psy findings mpletion of c	available
<b>8</b>	The law cate has page 2:	mo						auto peri 1 ☐ Yes	ormed? d	eath?	2√ No	2030 01
	(0) 7-6	a	25. Was case referred to medical			2	26. Place of Death		-24			
>	ysicia is cer direct	To B	examiner? 1 ☐ Yes 2½ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Other:	4 Nursing Ho	me 5 Res	idence 6 Othe	ır (Specii	y)	
0	ding Physician: h. After this certific funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. Injury a Work?		28d. Describe	how injury occurre	ed		
0	ittendin death. ctor: Af	atic	1 Natural 5 Pending 2 Accident investigation				s 2 No					
Division of	l or Attendated after deatl	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (\$	<ul> <li>At home, farm, st</li> <li>Specify)</li> </ul>	reet, factory, office		28f. Location City or To	(Street and Number own, State)	er or Rur	al Route Num	ber,
	itelo irs aft ral Di								( )			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	edical	(Check only 2 Medical Exam	ysician: To the best of m niner: On the basis of ex	amination and/or it	th occurred at the time, avestigation, in my opin	, date and place, nion, death occurr	and due to the red at the time	e cause(s) and mai , date and place, a	nner as s ind due t	tated. o the cause(s	;)
	the I the I	Med	29b. Signature and title of certifier	and manner stated	1.	29c. License n	number		29d. Date signed	(Month,	Day, Year)	
	5 W 5 2	-	250. Signature and title of certifiel			0227						
	_		30. Name and address of person who	nompleted course of death	h (Item 23s) /Tunn	Disa			July 3	1, 2	000	
)a	4		7 401 West Co.	The leve Ri	M. 112 6	Baltenine	Min.	land.	2/2/1			
	≠ St	ate	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature	Sa/Mnux	11.019	14/50/	11/100			
H	Regist		AUG 0 1 2	006 Secure	J. H. L	South i						

		1 - State Registrar	,		rtment of He tificate of D			eg. No.		
Physici	ian	1. Decedent's Name (First, Middle, Last)  Sherman Winfield	Dadass				2. Date of Dea Month	Day	Year	3. Time of Death 4:12 P
/Medic		4a. Facility Name (If not institution, give si	Dodson		4b. City, Town, or	Location of Death	July	28 4c. Count	2006 y of Death	4:12 P
Examir	ner	Baltimore Washingto		nter	Glen Bu				Arun	de1
Funeral Director		5. Social Security Number 6. Sex 214-05-2746 172	7. Age (In yrs. Ia M 2□F 89	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 01/22/1	9°17	9. Birthp Cour Mary	lace (State or Fore Tand
*		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	ation				1	0d. Inside City Lim
o ho	5	MD Anne Arui		adena	ation.					1 ☐ Yes 2 🔯
28a	rect	10e. Street and Number			10f. Zip Code		1	Og. Citizen of	What Cour	ntry?
3a o	ie O	7953 West River Sid	de Drive		21122			USA		
teme 2	Funeral Director	The Marital States	2. Was Decedent Ever in U.S Armed Forces?	S. 13. W	/as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ce - Americ	
o de	by F	1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ★o If Yes, Give Year or Dates:	1	□Yes 2□XXX	Specify:		Spec	⁄ሃ፡ Whi	te
ature cal E	ted	15. Decedent's Educ	ation	16a. Decede	ent's Usual Occupa	tion		16b. Kind of I	Business/In	dustry
Med "n	Completed	(Specify only highest grade	College (1-4or 5+)	life. D	and of work done done done done done done done done	uring most at won	ang	C = = + = = =		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Son		_	Pain	cer		(27)	Contra		
ed ot	Be	17. Father's Name (First, Middle, Last) George Winfield Doc	lson			18. Mother's Nam Myrtle	$\mathbf{E}_{ullet}$ Thoma		me)	
mark	2	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing	Address (Street a				n. State. Zin	Code)
27 ls r trau			on		Colonia					
item othe		20a. Method of Disposition	1 00	ace of Dispos	ition (Name of atory or other place	) I	Date	20c. Location	- City or To	wn, State
in in in		MBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	_	Cemetery		/2006	Annapo	lis,	MD
Department of results and welfare rayers in the properties of them 27 is marked other than "naturel", or iteme 23 a or 28 ar abow eny injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service License	9		Name and Address ardesty F 2 Ridgely				401	
physician and stransit tansit street burial-transit	ical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or	ence of):						
ttending or use a	Physician/Medi	IF FEMALE: 23 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnar	death 3 🔲	Ectopic pregnancy				ate of delive	ery Day Year
y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eatn 5	Other (specify)					
n signed by the a lid be deteched f	by	Part II. Other significant conditions conf	ributing to death but not resu	Iting in the un	derlying cause give	n in Part I.				ne cause of death
s been si	Completed						24a. Was a		Were auto	psy findings avail
ate hes page 2 :	mo						autops perfor		prior to condeath?	inpletion of cause
ctor.	BeC	25. Was case referred to medical examiner?				26. Place of Dea	- '			
this c	ဥ	1 ☐ Yes 2 ☑ No Ho		R/Outpatient		4   Nursing no	ome 5 Resid			v)
r: After e funer	ation:	27. Manner of Death  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 ☐ Y	at ? es 2 □No	28d. Describe h	ow injury occu	rred	
within 2 trougs are upon.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury · At ho building, etc. (Specify		et, factory, office		281. Location (Si City or Town		ber or Rura	I Route Number,
unera	dical (	29a Certifier Certifying Physical Check only one)	ician: To the best of my know er: On the basis of examinat and manner stated.	vledge, death ion and/or invi	estigation, in my op	a date and state inion, death occur	and due to the c red at the time, d	ause(s) and in ate and place	ia wer as si , and due to	the cause(s)
P 99	Me	29b. Signature and title of certifier			29c. License			9d. Date sign		
To the Foundation		Stroll Valle.	1111		ト カス	5718		07-3	0-2	826
within 24  To the F  complete		Jenni Mann	-1001		100	- / - 0			0	
within 24 To the F complete		3 Name and address of person who con Jaken Toockison Fel.	npleted cause of death (Item	23a) (Type 5	Print) And	Constit .	Les 2	1401	_	

			- State Amend Item 2	State of Maryland 3a per Dr., G8	d / Departn 58 <b>,08/29</b> <i>Certifi</i>	rent of Health a <b>706dhb</b> cate of Death	and Mental Hy	glene 006	25672
			1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day Year	3. Time of Death
	Physicia /Medic		Hattie Doris	Drawbaugh			AUGUST		8:20 P M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b.	City, Town, or Location	of Death	4c. County of Deat	
		4	RAVENWOOD LUTHERAL	N VILLAGE		AGERSTOWN		WASHINGTO	ON
	Funeral Director		215–18–2744	7. Age (In yrs. I		Inder 1 Year If Under on the Days Hours	Min. (Month, Da	y, Year) Co	hplace (State or Foreign ountry) rginia
	and wo		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Location	n			10d. Inside City Limits
	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show deat Examinat rust be incliffed at	ţ	Maryland Washing	rton	На	gerstown			1 ☐ Yes 2 X No
	or 28g	Funeral Director	10e. Street and Number		10	of. Zip Code		10g. Citizen of What Co	ountry?
	th wi	ai	19004 Cherry Tr	ee Drive		21	742	U.S.A	
	after dea or items	ner	11. Marital Status	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> </ol>	S. 13. Was I	Decedent of Hispanic Or , specify Cuban, Mexical	igin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
36	d 2 should be filed within 72 hours after de In and Mental Hyglene. 71 is marked other than "naturel", or liem treumatic event, the Medical Experimen	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give		es 2X No Specify:		Specify: Wh	ite
21215-0036	72 hours "naturel", idical Exe	ed b	15. Decedent's Edu	Year or Dates:	16a. Decedent's	Usual Occupation		16b. Kind of Business	Industry
7.	n "na	piet	(Specify only highest grad		(Give kind life. DO N	of work done during mos OT use retired)	t of working		·
212	filed within Hygiene. Sther than "sent, the wed	Completed	Elementary/Secondary (0-12)	2	Ho	memaker		Personal R	esidence
b	e filed al Hygi I other vent, I	Be	17. Father's Name (First, Middle, Last)			18. Moth	er's Name (First, Middle		
<u>ya</u>	ould be Mental arked o	은	Edward J. Hajed	:k			Hettie Ove		
Maryland	2 shoul and Me is marl reumati		19a. Informant's Name/Relationship (T)			,		er, City or Town, State,	
	s 1 and 2 if Health item 27 I		Dr. Edward Drawba		19004 (		Drive Hage	rstown Mary 20c. Location - City or	
ŏ	S		1 ☐ Burial 2X Cremation 3 ☐ F	Communities Charles	emetery, cremator	or other place) Crematory		Smithsburg	
Baltimore,	it. Pa intmer intent njury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>			me and Address of Facili			
Ba	permit. Page Department of Importent: If any injury or once.		Vi ) unala M	Fine			Douglas A	. Fiery Fue	nrai Home yland 21742
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line.	h. Do not enter the		cardiac or respiratory a		Approximate ree Interval Between Onset and Death
	/Medical Examiner		resulting in dealing	Due to (or as a consequ	uence of):	Pailur.	e to Thrive		4 months
		e.	if any, leading to immediate	b Due to (or as a consequ	uence of):	Fallu	e to Hitte		4 40110115
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	с.					
ó	sician and burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):				
68760,	ate be thysici the bu	icai	(	d					
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	I death 3 □Ecto	opic pregnancy er (specify)		23d. Date of de Month	livery Day Year
S, D	The law requires that the de ste has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underl	ying cause given in Part		tobacco use contribute lo	~
Record	w requir	Completed					24a. Was	an 24b. Were a	utopsy findings available
Re	The lav	omp				-	auto perfo	proprior to ormed? death? 2 No 1 ☐ Yes	completion of cause of
Vital		O	25. Was case referred to medical			26. Plac	e of Death (Check only		
>	Physicien: this certificand director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	□ DOA Other: 4.X N	ursing Home 5 🗆 Resi	idence 6 Other (Spe	ocity)
n of	ding Phone		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occurred	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			d 1 ☐ Yes 2 ☐		(Canada and November 2)	
Division	or Att	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, (y)	factory, office		(Street and Number or R wn, State)	u <i>r</i> a <i>i H</i> ouïe <i>Number</i> ,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical Co		vsician: To the best of my kno iner: On the basis of examina and manner stated.					
	omple	₩.	29b. Signature and title of certifier	. //		29c. License number	, _	29d. Date signed (Moni	th. Day, Year)
	← < lm ()					11 0 7.0	1 1	0 7 26	
•	, ,,,,		Marien	grap.		0283	,07	8-2-0	
)			30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type, Print	0283	,03	8-2-0-	7/240
کا	H-3		30. Name and address of person who of a year.  31. Date filed (Mobility Day, Year)	ompleted cause of death (Iten	n 23a) (Type, Print	gation, in my opinion, decoration in my opinion in my opinion, decoration in my opinion  ret Heefe	8-200 New 17D	2/740	

DHMH 17 Rev 1/2001

Washingan Ct.

DRAWBAUGH, Hettie D

			1 - For State Registrar	State	of Maryla		artment of ertificate o				giene 2	00	5 25673
			Decedent's Name (First, Middle, I	Last)				-		2. Date of Dea	ath		3. Time of Death
	Physici		Andree Jeanne D	eprit						Month July 28	Day 200	Year	11:44pm <sup>M</sup>
1	/Medic Examin		4a. Facility Name (If not institution, g	_+	umber)		4b. City, Town	, or Location		oury ze		nty of Dea	
			Shady Grove Adv	entist H	lospita	1	Rockvil	l1e			Mon	tgome	rv
	Funeral			. Sex		rs. last birthday	) If Under 1 Yea	ar If Under	r 24 Hrs.	8. Date of Birt	h	9. Bi	tholace /State or Foreign
	Director		534-60-7066	1 ☐ M 2 🕱 F	80	Yrs.	Months Day	/s Hours	Min.	(Month, Da) Dec. 17			ountry) Lgium
	P .		Usual Residence of Decedent								, -,		8-011
	how	_	10a. State 10b. County		10c.	City, Town or I	ocation						10d. Inside City Limits
	Pa-f	cto	Maryland Montgo	nery	Mo	ntgomer	y Villag	ge					1 ☐ Yes 2 🛣 No
	deeth with the Maryland ms 23s or 28s-f ehow croust be rediffed at	Directo	10e. Street and Number				10f. Zip Code	9			10g. Citizen	of What C	ountry?
	23a		19119 Roman Way				20886				United	l Sta	tes
	en and and and and and and and and and an	Funeral	11. Marital Status	12. Was De	cedent Ever in orces?	n U.S. 13	Was Decedent of	f Hispanic Or	rigin? (Spec	city Yes or No-		Race - Am Black, Whi	erican Indian,
õ	or It	F	1 Never Married 2 Married		2 XI No		1 ☐ Yes 2X N						
9500-612	ure!'.	d by	3 Widowed 4 Divorced	Year or	Dates:						Spe	wify:Wh	ite
ភ្ជ	72 h	Completed	15. Decedent's (Specify only highest)	Education grade completed	)	16a. Dec	edent's Usual Occ e <i>kind of work dor</i> DO NOT use reti	upation ne during mos	st of workin	ng	16b. Kind o	f Business	/Industry
2	Pan Pan	d L	Elementary/Secondary (0-12)	_	(1-4or 5+)			ired)					
Z	tygie t		17. Father's Name (First, Middle, La		+	Hon	nemaker	40.14-45		(Final 46) 4 (1)	Own I		
yland	be dial	Be		,						(First, Middle,		name)	
Ĕ	ould Mer narke	2	Joseph Bartholo							te Ross			
Z Z	le st le n		19a. Informant's Name/Relationship				ling Address (Stre						, 111,
d)	l end teelth m 27 her t		Etienne Deprit	(Son)	100		9 Roman	Way, Mo					
Ö	F It of F		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	☐Removal from		cemetery, cri	osition (Name of ematory or other p	olace)	Da	ate	20c. Locatio	n - City or	Town, State
	Lant:		4 Donation 5 Other (Spe										, Virginia
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mantal Hygiene. importment of Heelth and Mantal Hygiene. importment: if Item 27 is marked other than "neturel; or Items 23a or 28a-f show eny Injury or other traumatic event, Ita Macilian Examination must be notified at once.		21. Signature of Funeral Service Lie	ensee (			22. Name and Add 10 East Gaithers	Deer P	ark D	ol Fund rive	eral H	ome	
			23a. Part LEnter the disease, or co	emplications that	caused the d						rest,		Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final	_	_								Interval 8etween Onset and Death
	/Medical		disease or condition resulting in death)	a	Cance	sequence of):							Months
	Examiner					ular Co	112000						Minutos
		ē	Sequentially list conditions, if any, leading to immediate	D	(or as a cons		ттарье						Minutes
	uted d ansit	声	cause. Enter Underlying Cause (Disease or injury that initiated events	Resn	irator	y Distr	'ACC						Minutes
ĵ	exec n an ial-tr	Examiner	resulting in death) Last	Due to	(or as a cons	sequence of):							Himaces
8/60,	ficate be executed physicien and s the burial-transit	dicai		d.									
ĝ	tificat g phy as th	ed									1		
X Q	w requires that the deeth certif been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, of	utcome of pre		05				23d.	Date of de	livery
<u>מ</u>	deetl	icia	in the past 12 months? 1 ☐ Yes 2 ☒ No	4∐Preg	nant at time o		□Ectopic pregnar □ Other (specify)					Month	Day Year
j.	t the by th ache	hys	9 ☐ Unknown	9□ Unk	nown								
, ,	requires that een signed b nould be deta	by P	Part II. Other significant conditions	s contributing to	death but not	resulting in the	underlying cause	given in Part	i.	23e. Did to	bacco use c	ontribute t	o the cause of death?
rds,	quire in sig uld b									1 🗆 Y	es 2□No	3 □ P	robably 4 XUnknown
Ö	law re as bee 2 sho	ompieted								24a. Was	an 24	b. Were a	utopsy findings available
ĕ	a <del>-</del> a	E								autop perfo	sy med?	prior to death?	completion of cause of
VItal	ician: Th certificate ector, pag	Ü	25. Was case referred to medical	_				00. 81.	- 40	1 Yes	-	1 ☐ Yes	s 21☑ No
		0	examiner? 1 ☐ Yes 2 🛣 No	Hospital:	I Innatiant C	2 □ ER/Outpatie	ent 3KI DOA	Ther.		Check only o		211 /0	4.
Ö	ding Phys h. After this funeral di		27. Manner of Death	28a. Date	of Injury	28b. Time	AIL SES DOA	4 🗆 141		ne 5 Resid			эсіту)
5	th. After	ij	1 X Natural 5 ☐ Pending 2 ☐ Accident investigat		nth, Day Year	r) Injury		∛ork? ∐Yes 2.∐			,,		
UNISION	Atter dea	ertification:	3 ☐ Suicide 6 ☐ Could no	be 28e. Place	e of Injury - A	it home, farm, s	treet, factory, office			8f. Location (S	treet and Nu	mber or R	ural Route Number.
5	spital or Attanding Fours after death. In a Director: After filled in by the funer.	Certi	4 Homicide	buile	ding, etc. (Sp	ecify)	,,,,			City or Tow	m, State)		
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 ☑ Certifying (Check only one)	aminer: On the	ne best of my basis of exam nner stated.	knowledge, dea	th occurred at the	time, date ar y opinion, dea	nd place, a	nd due to the o	ause(s) and date and plac	manner a e, and du	s stated. e to the cause(s)
	To the within ?	Me	29b. Signature and title of certifier	0	, stated.		29c. Lice	ense number			29d. Date sig	ned (Mon	th, Day, Year)
			7.	/ha	1	-	C	335	04		July 2	8. 20	006
	10		30. Name and address of person wh	no completed cau	use of death (	Item 23a) (Type	, Print)	, , , 0	- 1		- 41 / 2		
			Poopak Bakhtiar:	i MD, 9901	Medic	al Cent	er Drive	, Rock	cville	e, MD 2	0852		
	Sta		31. Date filed (Month, Day, Year)			gnature							
_ A	Registr	ar	AUG 01	2006	PARKER	N. 19							

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [

			1 - For State Registrar	State of M	laryland		artment of H			iene 2 () ()	6 25674
			1. Decedent's Name (First, Middle,	Last)					2. Date of Death	n	3. Time of Death
	Physici /Medi		MARVIN	Н.			DANZI		JULY 29,		1:00 A M
1	Examir	er	4a. Facility Name (If not institution,				4b. City, Town, or		ath	4c. County of E	
	· · · · · · · · · · · · · · · · · · ·		BROOKGROVE NURS				SANDY S	PRING  If Under 24 Hr			NTGOMERY
	Funeral Director		5. Social Security Number 055-20-0843	. Sex 7. Aq 1 1 2 F	ge ( <i>In yr</i> s. las 79		Months Days	Hours Min	n. (Month, Day,	Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		12				AUG 7, 1	920 NE	W YORK
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maried	tor	MD MONTO	GOMERY			S	ILVER SE	PRING		1 Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	t Country?
	23a		15107 INTERLACHE	N DRIVE #2	26			20906		U.	S.A.
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? ( n. Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow he Madical Exemirer must be multised at	<b>by</b> Ft	1 Never Married 2 Married	If Yes, Give	AA AA T	Т	1 ☐ Yes 2 🙀 No	Specify:	,	Specify:	WHITE
8	tural	pa pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:			dent's Usual Occupa	ation .			
Ċ	in 72 an" r	Completed	(Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	during most of w	orking	6b. Kind of Busine	ess/industry
7	lene.	E	Elementary/Secondary (0-12)	College (1-4or		TNDIIS	TRIAL ENG	TNEER		SETE/C	OVERNMENT
ğ	ent,	Bec	17. Father's Name (First, Middle, La	st)			TITLE DITT		ame (First, Middle, M		OVERMIENT
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f ehow entry intry or other treumatic event, the Madical Examinar must be nutified at an ance.	To B	DAVID DANZIGER					GERTRUE	E FRIEDLA	NDER	
ar)	2 sho and I is ma		19a. Informant's Name/Relationship						Rural Route Number,		
	and lealth m 27		JANET I. DANZIGE	K/WIFE				CHEN DR	-		NG, MD 20906
ŏ	Pages 1		20a. Method of Disposition 1 Disposition 2 □ Cremation 3	☐Removal from State	cem	etery, cren	sition (Name of natory or other place			loc. Location - City	
altimore,	t. Pa ntmen rtant:		4 □Donation 5 □Other (Spe		MT.				1/2006 A		
Ba	Depariment of the part of the		21. Signature of Funeral Service Lice	ensee		$D_{A}^{22}$	NZANSKY-C	s of Facility OLDBERG	MEMORIAL	CHAPELS	, INC.
			23a. Parl 1. Enter the disease, or co	mulications that cause	d the death	111	10 KOCK VI	TPPE BIK	E, ROCKVI	LLE, MAR	YLAND 20852 Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each l	ine.	DO HOL OH	or the mode of dying	y, such as cardio	ac or respiratory arre	51,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in dealh)				CARDIOVAS	CULAR D	ISEASE		YEARS
	Examiner			Due to (or as			ISTON				YEARS
		ē	Sequentially list conditions, if any, leading to immediate	D	a consequer		IDION				ILAKS
	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
ó	en ar urial-t	Ĕ	resulting in death) Last	Due to (or as	a consequer	ice of):					
8760	The law requires that the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dlcal		d							
9	entific ling p	Mec	IF FEMALE:								
Box	eath certific attending p	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal de	alh 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
o.	at the de by the a tached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of deat	n 5∟	Other (specify)				<b></b> ,
O_	res that i igned by be deta	F.	Part II. Other significant conditions	contributing to death b	out not resulting	ng in the ur	iderlying cause give	n in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
Records,	uires sign	d by							1 ☐ Yes	s 2 □ No 3 □	Probably 4 XUnknown
S	w require been si should t	lete							24a. Was an	24h Were	autopsy findings available
	The law cate has page 2 s	Completed							autopsy perform	ed? prior death	to comptetion of cause of
Vital		0	25. Was case referred to medical					26 Place of De	1 ☐ Yes 2 eath (Check only one		fes 2□No
	ysici is cer direc	OB	examiner? 1  Yes 2 No	Hospital:	ent 2□ER	/Outpatien	3 □ DOA Othe		Home 5 Residen		(nacifu)
ō	ding Ph h. After th funeral	Ä.	27. Manner of Death  1X Natural 5 Pending	28a. Date of Inju	ıry 28	b. Time of Injury	28c. Injury Work	at	28d. Describe hov		роспу
<u>0</u>	tendir leath. tor: Af the fur	ate	2 Accident investigat	on	, , , , ,	jury		es 2 □No			
Division of	of after death after death I Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 289. Place of Inj	ury - At home c. (Specify)	, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director,		20 0 V							,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  A Certifying I  2 Medical Ex	Physicien: To the best aminer: On the basis o	t examination	dge, death and/or inv	occurred at the time estigation, in my op	e, date and plac inion, death occ	e, and due to the cau curred al the time, dat	use(s) and manner te and place, and d	as stated. due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signalure and title of certifier	and manner st	aleu.		29c. License			d. Date signed (Mo	
)			Bustler	كالند				D2395		ULY 30,	
	10		30. Name and address of person wh	o completed cause of o	leath (Item 23	a) (Tyne F	Print)	5237	, ,	JII JU,	
			BURT I. FELDMAN,	MD 3305 NO	RTH LE	ISURI	E WORLD B	LVD, SII	LVER SPRIN	G, MD 20	906
	Sta		31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	Ro	arks)	-			
12.	Registr	ar	AUG 01	2006	10 10	Pala					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ıryland	•	rtment o			nd Mental F	lygien Reg. N		C 21	5675
100	W*.	4	Decedent's Name (First, Middle, Last)							2. Date of Month	Death	C. U.U.		me of Death
8	Physici /Medic		Martin Dierks							July	28,	2006	ear 11:	08 a M
1	Examir	er	4a. Facility Name (If not institution, give stre	et and number)			4b. City, To	wn, or Lo	ocation of [	Death	4	c. County of D	Death	
	Funeral Director		11430 Amherst Aven 5. Social Security Number 6. Sex 504-36-1741 15x M		8 (In yrs. las 73	st birthday) Yrs.	If Under 1 \	Year I	pring f Under 24 Hours		Birth Day, Year 30, 1	0	<u>fontgon</u> Birthplace (S Country) est Ger	tate or Foreign
÷	pu ,		Usual Residence of Decedent		10. 07					1				
	shov	2	10a. State 10b. County			Town or Loc							i	de City Limits
	28a-f	Director	Maryland Montgomer  10e. Street and Number	У	511	lver S	10f. Zip Co	ode			10a C	itizen of Wha		
	3a or		11430 Amherst Aven	ue, Apt.	8		20902					Germa		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By a marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exercitrant ten notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If	Vas Deceden Yes, specify	Cuban,	Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-		American Indi White, etc. Thite	an,
Maryland 21215-0036	rithin 72 ho ne. hen "natur Medical	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12) 1 2	on ompleted) College (1-4or 5-		(Give I lite. C	ent's Usual C kind of work of OO NOT use	done duri	on ing most o	f working		Kind of Busine		
2	Hygier Hygier ther ti		17. Father's Name (First, Middle, Last)			1	ailor	1.9	R Mother's	Name (First, Mid		ilor S	Shop	
and	d be f	To Be	Karl Heinrich Die	rks				,,,		nda Gert				
ary	shoul nd Me mark	ř	19a. Informant's Name/Relationship (Type,	Print)		19b. Mailin	g Address (S	treet and		or Rural Route Nu			te, Zip Code)	
ž	and 2 alth a 1 27 la		Patsy L. Alder/ Fri	end		2300	Blue F	Ridge	e Ave	nue, Apt	. 303	, Whea	ton, M	D 20902
Baltimore,	Pages 1 and the nent of He nut: If item		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	cen	netery, crem	sition (Name latory or othe n Cremat	r piace)	J	uly 30, 2006			or Town, Sta	rginia
Balt	permit. Departr imports any inje		21. Signature of Funeral Service Licensee	Les		Fr 50	ancis O Univ	deress (	6711 ity B	ns Funer 1vd, W,	al Ho	me Inc		
· * .	Physician /Medical		23a. Part 1. Etter the disease, or complicat shock, of heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	Lung	e. C 0	ance		f dying, s	such as ca	rdiac or respirator	y arrest,		Interva	kimate al Between and Death
16	Examiner	er	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause, Obsease or injury	Due to (or als a							-			
8760,	cate be executed physician and i the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):											
O. Box 6	requires thet the death certifica sen signed by the attending ph hould be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown	2 ☐ Fetal de	eath 3 🗍	Ectopic pregr Other (speci				-	23d. Date of Month	delivery Day	Year
rds, P	w requires thet been signed b should be deta	by	Part II. Other significant conditions contrib	uting to death bu	t not resulti	ng in the un	derlying caus	se given i	in Part I.	,	_/	_	e to the caus	e of death? 4 ∐Unknown
al Records,	The law ste has t page 2 s	Completed									itopsy informed?	prior death	to completion h?	
Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	oital:				Other		Death Check on	1			
Division of	Attending Physician: or death. sector: After this certifice by the funeral director.	atlon: To	10 163 5700	1 ☐ Inpatien 8a. Date of Injury (Month, Day		Outpatient  Bb. Time of Injury		Injury at Work?		ng Home 5 5			Specify)	
Divis	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injur building, etc.	ry - At hom (Specify)	e, farm, stre	et, factory, or	fice			n (Street a Town, Stat		r Rural Route	Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completely filled in by the funeral Director.	Medical	29a. Certifier (Check only one)  Certifying Physicia Certifying Physicia Check only one)	On the basis of and manner state	examinatio	edge, death n and/or inv	estigation, in	my opini	on, death	place, and due to to occurred at the time	e, date an	d place, and	due to the ca	
)		~	29b. Signature and title of certifier	msko	Mi	ry, h	29c. L	D5	1916	?	1 J W	ite signed ( $M$	8, 20	ar) 06
			30 Name and address of person who comp Part Ca TOMSKO 31. Date filed (Month, Day, Year)	ated cause of de de de de de de de de de de de de de	11117	ROC	KVI /	le f	Pike	G-100)	Roc	kvij	le, Mi	20852
. Si.	Sta Registr	100	JUL 3 1 200		3 Gigitatu	1 Apr	30%)			Ź				

			1 - State of Mary		artment of H			giene Reg. No.	06	25676
			Decedent's Name (First, Middle, Last)				2. Date of Day	ath	Vaar	3. Time of Death
	Physici /Medio		Elsayed Aly	Elmog	ghazy		7/3	0/2006	Year	7:13p M
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County		
			Suburban Hospital		Betheso	la If Under 24 Hrs.		Montg		
	Funeral Director		267-29-1661 1 <sup>™</sup> 2□F	61 Yrs. last birthday)	Months Days	Hours Min.	8. Date of Birt (Month, Da 7/20/	y, Year)		place (State or Foreign ntry) ypt
	and wo		Usual Residence of Decedent           10a. State         10b. County         10	c. City, Town or Lo	cation				1	10d. Inside City Limits
	Mary -1 eh	to	Md. Montgomery I	Bethesda	1					1 ☐ Yes 2√☐ No
	ith the Marylan or 28a-f ehow	irec	10e. Street and Number		10f. Zip Code	_		10g. Citizen of W	hat Cour	ntry?
	23a c	Funeral Director	7401 Westlake Terrace		2081	7		U.S.A.		
	atter dea or Items	nue	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13. \	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americ c, White,	can Indian, etc.
036	within 72 hours after death with the Maryland sne. Than "natural", or Items 23s or 28s-f show he Madical Examiner must be notilled at	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		I□Yes 2XX No	Specify:		Specify.	wh	nite
5-0	72 hours "natural", adical Ex	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation during most of work	ing	16b. Kind of Bu	siness/In	dustry
121	vithin hen	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			)		- 1		
2	Hygie thar t	ပိ	17. Father's Name (First, Middle, Last)	Proi	essor	18. Mother's Name	e (First, Middle)	Educa Maiden Sumami		n
and	d be ental ked o	To Be	Ali Elmoghazy			Fatima		moghazy		
2	shound M	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street a	and Number or Rura	al Route Numbe	er, City or Town,	State, Zip	code) 20817
Ž	and 2 alth a 27 to		Ibrahim Elmoghazy/son	7401	Westla	ke Terra	ace,Ap	t#812 E	eth	esda,MD
Baltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be filed within 7/8 Department of Health and Mental Hygiens Important: if I tem 27 is marked othar than "in any injury or gihar traumatic event, ins Madions.		20a. Method of Disposition  1 ☼ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)		natory or other plac	nal 7/3	Date 1 / 0.6	20c. Location -		
#	mit. F sortar injur	1 9	21. Signature of Funeral Service Ligensee	_	. Name and Addres			al Mort	<u> </u>	
ä	99 4 8	7 8	1 mm Marty	4	11 Kenn	edy St.				
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a condition or should be condition or should be condition or should be condition.	ardial	T	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
√ 68760.	ifficate be executed by g physicien and st the burial-transit	edical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a condition of the							
ghaz,	the death cert y the ettendin iched tor use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)	. 747.		23d. Date Mon		ery Day Year
/M0	Se us	þ	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	10 -	obacco use contri res 2 🗆 No		he cause of death? pably 4 Junknown
$\mathcal{S}_{Recol}$	≥ <u>□</u> ₩	Completed	Coronary Artery	Disp	ase		24a. Was autop perfor	rmed?/ d	/ere auto rior to cor eath?	opsy findings available impletion of cause of
γcο	- 5 G		25. Was case referred to medical			26. Place of Death	1 ☐ Yes	20 No 1	Yes	3/No
\ \times \( \)	Physician: this certific	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe			ne) dence 6 □Othe	r (Snacil	5 <sub>0</sub> 1
15/ 10 no	ding After tune	tion: T	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Ye	28b. Time of	28c. Injury Work			now injury occurre		<i>N</i>
	l or Attendatter deatl Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, stri			28f. Location (S City or Tow	Street and Number on, State)	r or Rura	al Route Number,
38	urs at urs at eral D	Ce								
1/30	the Hospital nin 24 hours a the Funeral I	ledical	29a. Certifier (Check only one)  Certifying Physician: To the best of machine in the desired form of the desired form one)	amination and/or inv	occurred at the tim restigation, in my op	ie, date and place, pinion, death occurr	and due to the o	cause(s) and mar date and place, a	ner as si nd due to	lated. o the cause(s)
	To the within 2 To the complet	Σ	29b Signature and title of certifier		29c. License	number		29d. Date signed	(Month,	Day, Year)
A.	8		Emergency Phy	sician	D00	5477.	6	+/3	>0/	06
			30. Name and address of person who completed cause of death		.h. ch.	Hospit		O Old G nesda,	eor Md.	getown Rd. 20814
	Sta	to-	Barth Leonard Mi 31. Date filed (Month, Day, Year) 32. Megistrar's	Signature 4	burban	1   0   1	Beci			200.1
	Registr		AUG 0 1 2006	Signature	als					

Registra AMEND#23a(b)perMD8/1/06,BMW,MbCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Mary Elizabeth Edwards 27 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5+ Agnes

5. Social Security Rumber Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 21, 1924 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 X F 81 212-20-2154 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County e filed within 72 hours after death with the Marylan
II Hygiene other then "natural", or Items 23e or 28e-f show
only, the Medical Exercity or the motified at Maryland Baltimore Catonsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 147 Sanford Avenue 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 □ Yes Z No Specify: Race · Anc. Black, White, etc. White 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify þ 31 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0,12) Keypunch Operator IBM permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygies
Important: If Item 27 is marked other it
any injury or other trsumatic event, if it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Horace Elmer Pilkerton Frances Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4441 Stonecrest Drive Ellicott City, Md. 21043 Robert E. Edwards -son 20c. Location - City or Town, State 20a. Method of Disposition

YE Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans Cem. 8/2/2006 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** nronic renal /Medical Due to (or as a consequence of): Examiner Malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. edwards Maru ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 1 npatient 3 DOA After this

23e. Did tobacco use contribute to the cause of death?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

Day

3. Time of Death

9. Birthplace (State or Foreign Country) Mary Land

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 No

8.03 PM

28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

27. Manner of Death 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST-

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

900 CATONAVE. BALTIMORE, MD. 21229

(Check only one) 29b. Signature and title of certifier

HAFSA KHAN

4 Homicide

29a. Certifier

29d. Date signed (Month, Day, Year) 29c. License number

18606

28,2006

Registrar

Certification:

Medical

31. Date filed (Month, Day, Year) 2006 AUG 01

AGWES

or Attending

after death.

To the Hospital of within 24 hours at To the Funeral D

3

			State of Maryland I Per ME G858	Cer	tificate of L	Death	2. Date of De		25678
Physici /Medi		1. Decedent's Name (First, Middle, Last)  Edward Scott 1	Eskridge				July 2	Day Year	1500 M
Examir		4a. Facility Name (If not institution, give st 11319 School Ho			4b. City, Town, or Mardela			4c. County of Dea	
Funeral Director		215-62-0906	7. Age (In yrs. last 51	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bin (Month, De Dec. 18	th 9. Bir y, Yeer) 9. Bir 3, 1954	thplace (State or Foreign ountry) DeLaware
aryland show dat	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County  MD Wicomic	10c. City, T		cation a Springs				10d. Inside City Limits 1 □ Yes 2 No
vith the Mi or 28a-f be couldle	Director	10e. Street and Number			10f. Zip Code 218			10g. Citizen of What C	ountry?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene titem 27 is marked other then "natural; or items 23a or 28a-1 show other traumatic event, the Madical Exametral count on notified and other traumatic event, the Madical Exametral count on notified and other traumatic events.	by Funeral	11319 School Hous  11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ₺ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)		ite, etc.
ed within 72 hours aft giene. er then "natural", or i the Wedleal Exam	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation 1	(Give life. L	ent's Usual Occupa kind of work done of DO NOT use retired,	furing most of work )	ing	16b. Kind of Business	
nd 2 should be filed wit lith and Mental Hygien 27 Is marked other the r traumatic event, the	Be Con	12 17. Father's Name (First, Middle, Last)	n.a	Macn	ine Opera		e (First, Middle	Nylon Fact , Maiden Surname)	LOLY
2 should be and Mental I s marked o	ToE	Earl E. Eskridge, 19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a	Beulah und Number or Run		m er, City or Town, State,	Zip Code) 21837
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once.		Earl E. Eskridge,  20a. Method of Disposition  1 Strial 2 Cremation 3 Case 4 Openation 5 Other (Specify)	20b. Plac	e of Dispo	3 Riverto		Rd. Mar Date 1/2006	dela Sprin 20c. Location - City o Hebron, MD	r Town, State
permit. Pages 1 a Department of Hez Important: If Item any injury or othe once.		21. Signature of Funeral Service License		22	. Name and Addres	s of Facility	13 E. G:	rove St, De	1mar,DE 1994
Pnysician /Medical		23a. Part1. Erter the disease, or cornelic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. e cause on each line.  Due to (or as a consequent	+	TSCV D	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
xaminer and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer						
certificate be executed ding physicien and se as the burial-transit	edicai	IF FEMALE:	c. If yes, outcome of pregnanc	v			<u>-</u>	23d. Date of de	alivery
es that the death certifigned by the attending be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)			Month	Day Year
law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	ributing to death but not resulti	ng in the u	nderlying cause give	en in Part I.		tobacco use contribute Yes 2 □ No 3 ☑	to the cause of death?  robably 4  Unknown
The ate h page	Completed						24a. Was auto perfo 1 Yes	psy prior to death?	autopsy findings available completion of cause of s
ling Physician n. After this certifi funeral director	tion; To Be	25. Was case referred to medical examinar?  1  9		VOutpatien Bb. Time of Injury	28c. Injun Work	4 ∐ Nursing Ho	ome 5 Tesi	idence 6 Other (Sp how injury occurred	ecify)
of or Attending after death. I Director: After din by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, str	eet, lactory, office			Street and Number or F wn, State)	Rural Route Number,
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical C		ician: To the best of my knowle er: On the basis of examination and manner stated.						
To the withing to the Comp	Me	29b. Signature and title of certifie			29c. License			29d. Date signed (Mor	nth, Day, Year)
1000		30. Name and address of person who co	npleted cause of death (Item 2		Print) Se	alistry	2180	21	
Si Regis	ate rar	31. Date filed (Month, Day, Year) AUG 0 1 20	32. Registrar's Signatur	е					

		-	For State of Man		rtment of Health		ygiene Reg. No. 200	5 25679
			Decedent's Name (First, Middle, Last)			2. Date of D	Death Day Yea	3. Time of Death
	Physici /Medic		Anthony Leo Fedele			2019	31, 300	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locatio	n of Death	4c. County of De	
*			Washington County Hospital	de la biotholosia	Hagerstown If Under 1 Year   If Und	er 24 Hrs. 8. Date of B	Washing	Ston  Birthplace (State or Foreign
H	Funeral Director		146-20-2938 ¹™ <sup>2□</sup> F 7	(In yrs. last birthday) Yrs.	Months Days Hours	Min. (Month, L	Day, Year)	Country)  W Jersey
	fand		Usual Residence of Decedent           10a. State         10b. County         1	Oc. City, Town or Loc	cation			10d. Inside City Limits
	Mary	ţ	FL Indian River	Vero Bea	ch			1 X Yes 2 □ No
	th the	lred	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?
	23a	ral	835 18th St.		32960		U.S.A.	
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23s or 28s-f show or other treumatic event, it a Medical Examinar must be notified at or other treumatic event, it a Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Event Armed Forces?  1 X Yes 2 No If Yes, Give Year or Dates:	1944	Was Decedent of Hispanic of Yes, specify Cuban, Mexicon Specify Towns of Specify No. Spec		Black, W	mencan Indian, hite, etc. White
5 0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during m	ost of working	16b. Kind of Busine	ss/industry
21215-0036	ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired) Representati	Ve	United Au	to Workers
5 D	filed v Hygie ther t	မ င၀	17. Father's Name (First, Middle, Last)	UIIIUII		ther's Name (First, Midd		LO WOLKELD
au	ld be ental ked o	To Be	Gerardo Fedele		Fi	llomena Elar	io	
Maryland	shou and M s mar		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Nur			e, Zip Code)
Σ	and 2 salth on 27 i		Ethel D. Fedele/Wife	D 0500	18th St., Ver		-	T 000
altimore,	ges 1 t of H <sub>t</sub> or oth		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State		natory or other place)	Date	20c. Location - City	
ţ	tment tent:		4 ☐ Donation 5 ☐ Other (Specify)		n Cemetery	8/4/2006	Hagerston	
Bai	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licensee  S. Mark Surp		Name and Address of Fa			-
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not ente		as cardiac or respiratory		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a death)	consequence of):	LIVIONAL	<u> </u>		YEAR
	Examiner		Sequentially list conditions, b.	ULMO	v try bty	PENTENS	10W	4 120
_	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):		Obstantio.	Plan	in an inst
	xecuti and	хап	that initiated events c.	consequence of):	Chvonic	C13540 2.610.	Discourse	yeu.
8760,	sate be executed obysician and the burial-transit	a		CBACC	0			Leavs
9	tificate ng phys as the	B	TE SEAM S					/
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and one 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. tf yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Da <sub>y</sub> Year
, P.O	res that t signed by be detact		Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Pa	urt I. 23e. Di	d tobacco use contribut	e to the cause of death?
rds	quires in sign	ed by	ESRD on dialysi	5			yes 2□No 3□	Probably 4 Unknown
of Vital Records,	The law requireste has been singled as page 2 should it	Completed	Recont Septica	nia - s	Steph Epid	Zfinia (S 24a. W au pe 1□ Yes	topsy prior formed? death	autopsy findings available to completion of cause of n?  Yes 2 \sum No
/ita	icien: certific rector,	Be	25. Was case referred to medical example ?			ace of Death Check onl	y one)	
<b>→</b>	Physic this c	2	1 Odes 2 No Hospitat 1 Inpatient 27. Manner of Death 28a. Date of Injury			Nursing Home 5 Re	esidence 6 Other (5	ipecify)
uc C	ding F	i oi	1 Netural 5 ☐ Pending (Month, Day	Year) Injury	f 28c. Injury at Work?  M 1 ☐ Yes 2		e now injury occurred	
Division	or Attendition of Att	Certification:	2 Could not be	y - At home, farm, str (Specify)		28f. Location	(Street and Number of Town, State)	Rural Route Number,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of and manner state and manner state	examination and/or in				
	To the within To the comp	×	29b. Signature and title of certifier	il(l)	29c. License numb	+7556	29d. Date signed (M	onth, Day, Year)  1 - 2006
151	1.5+1		30. Name and address of parson who completed cause of dea	ath (Item 23a) (Type,	Print) 136 OPALO	CXMTILL	FORTH IN	1140 2174
	-		31. Date filed (Month Day, Year) 32. Registrar	's Signature	1900145	THE STATE OF THE S	CEIS IULIA	JMD 21 to
	St Regist	ate trar	AUG 0 2 2006		-			
DH	MH 17 Rev 1/2	2001	AUG 11 & 2010 Jaken	~ B. A	oua		O. C. C. Comments	
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			1 State	State of	Maryland / De			ivi <del>c</del> iliai i iy	gienę U	Ub A	5680
		-	Registrar			ertificate of	Death	1000000	Reg. No.		
	Physici	an	Decedent's Name (First, Middle,	•				2. Date of De Month	Day Day	Year	ime of Death
	/Medic	cal	Patricia Wald			th Ch. T-	or Location of Deal	July 3	1, 2006 4c. County		:47 A.™
	Examin	ier	4a. Facility Name (If not institution,		Oer)		or Eggation of Deal	(f)			
-	Funeval	3),	623 Oyster Bay (		. Age (In yrs. last birthd	Dowell (ay) If Under 1 Yea	r If Under 24 Hrs	8. Date of Bi	Calv		State or Foreign
	Funeral Director		263-42-2196	1□M <b>X</b> □F	74 Yrs	Months Day	s Hours Min.	8. Date of Bir (Month, Da March	22. 1932	Pennsy.	State or Foreign
			Usual Residence of Decedent							10-1-07	
	ehow	h	10a. State 10b. County		10c. City, Town o	r Location					side City Limits
	Ba-f e	cto	Maryland Calve	rt	Dowell					11	Yes ZEINO
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?	
	s 23s	Funerai	623 Oyster Bay (			20629			United		
	ier de Item	nue	11. Marital Status 1 □ Never Married 2X Marrie	12. Was Deceded Armed Force d 1  Yes	es?	<ol> <li>Was Decedent of If Yes, specify Cu</li> </ol>	Hispanic Origin? (S ban, Mexican, Puer	specify Yes of No to Rican, etc.)	Blac	e - American Ind ck, White, etc.	lian,
36	irs af	by F	3 Widowed 4 Divorced	If Yes, Give		1□Yes X□N	o Specify:		Specify	"White	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-1 ehow ta Musical Exemiter musi & mulified at	ted	15. Decedent's	Education	16a. De	ecedent's Usual Occi	upation		1	usiness/Industry	
215	hin 7	pie	(Specify only highest Elementary/Secondary (0-12)	College (1-4	for 5+)	ive kind of work don e. DO NOT use retir	e during most of wo red) Preside	nt nt			
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nd	be file fal Hy d oth	Be (	17. Father's Name (First, Middle, La	•					, Maiden Suman	10)	
yla	2 should be filed withir and Mental Hygiene. ie marked other than aumatic event, Ite Ma	P	Eugene Robert Ca					May Hago	·		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "neture!; or items 23e or 28a-f ehow important: if item 27 ie marked other than "neture!; or items 23e or 28a-f ehow any injury or other traumatic event, it a five item is any injury or other traumatic event.		19a. Informant's Name/Relationship Walter Holtsmast			ailing Address (Stree					)
	1 and 2 Health tem 27		20a. Method of Disposition	ter (nuspa		O. Box 23.	z, bowerr	Date Date		City or Town, S	lata.
Baltimore,	Pages nent of H int: if Ite		1 Burial 2 Cremation 3		ate cemetery,	crematory or other pi	· 1				
ΙΞΉ	permit. Pag Department Importent: i eny injury o		4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie		Metropo	litan Cre	matory $8/$		Alexand		
Ba	permit. Departrimports ony injude.		21. Signature of Pulleral Service El	1 A		4405 Broomes				•	
			23a. Part1. Enter the disease, or co	DV.					eturic, :	THE YEAR A	20070
1.3				omplications that cau	used the death. Do not				irrest,		oximate
	Dhysisian		shock, or heart failure. List or Immediate Cause (Final	omplications that cau nly one cause on eac	ch line.	enter the mode of dy	ring, such as cardia	c or respiratory a		Inten	ral Between it and Death
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O. Box 68760,	death certificate be executed  Examine attending physician and ider use as the burial-transit	cai	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a	ras a consequence of):  ras a consequence of):  ras a consequence of):  ome of pregnancy  the 2 Fetal death  at at time of death	enter the mode of dy	ring, such as cardia	c or respiratory a	23d. Dal	PR 21	ral Batween tand Death MONTAL
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Registrar DHMH 17 Rev 1/2001

		For State Registrar	State	e of Ma	ıryland		artment of <i>tificate o</i> i			Mental Hy	/giene Reg. No	4000	25681
		1. Decedent's Name (First, Middle	e, Last)							2. Date of D	eath Da	v Year	3. Time of Death
Physicia /Medic		Margaret Eliz	abeth J	Flynn						July			5:55 P M
Examin		4a. Facility Name (If not institution	, give street and	d number)			4b. City, Town,	or Location	on of Death		4c	. County of Dea	h
	•	Holy Cross Ho	spital				Silver	Spr	ing			Montgo	mery
Funeral		5. Social Security Number	6. Sex		(In yrs. las	st birthday)	If Under 1 Yea Months Day		der 24 Hrs.	8. Date of 8	irth	9. Bir	hplace (State or Foreign
Director		228-30-2818	1 □ M 2 <b>/</b> □	MF	81	Yrs.	Months Day	S Hour	IS WIII.				hington, DC
2		Usual Residence of Decedent											
nylar show	_	10a. State 10b. County			10c. City,	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2√2 No
Be-f	cto		ntgomery	7	_Silv	ver Sr	oring						
be filed within 72 hours after deeth with the Maryland be filed within 72 hours after deeth with the Maryland by their by them "state", or items 23s or 28s-f show do other then "natural", or items avent, the Madical Examiner must be notified.	i Director	10e. Street and Number 13207 Betty L	ane				10f. Zip Code 2090				10g. Cit	tizen of What Co USA	ountry?
deeth	Funerai	11. Marital Status	12. Was	Decedent E	ever in U.S.	.   13. y	Was Decedent of	Hispanic	Origin? (Sp	ecify Yes or N	0-	14. Race - Ame	
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g sin s	by	3 ☐ Widowed 4 ☐ Divorced	It Yes Year	s, Give or Dates:			I□Yes 2.2XN	o Spec	city:			SpecifyWhi	te
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uid b Ment	2	Anthony W. Car	nnella						Barba	ara McG	rath		
s mand l		19a. Informant's Name/Relations	hip <i>(Type, Print)</i>	)			•					or Town, State, 2	
end 2		Brian Flynn/ So	on			13207	<sup>7</sup> Betty	Lane	, Silv	ver Spr	ing,	MD 209	04
S THE T		20a. Method of Disposition	2 - Dames - 14	Ctoto	20b. Pla	ce of Disponetery, cren	sition (Name of natory or other p	lace)	Augu	St 2,	20c. L	ocation - City or	Town, State
San Hard		1  Burial 2  Cremation 4  Donation 5  Other (S		rom State	Gate	of Hea	ven Cemet	ery	200		Silv	er Spri	ng, Maryland
permit. Pages t end 2 should be filed within 72 hours after deeth with the Marylan Deparmit. Pages t end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelin and Mental Hygiene.  Department of Heelin 27 is marked other than "natural, or iteme 23a or 28e-1 ehow any injury or other treumatic event, the Martical Examinar must be notified at once.		21. Signature of Funeral Service	Licensee	)	•	F2	Affers Ad	ress et 5	rivins y Blvd	Funera	l Ho	me Inc. r Spring	, MD 20901
		23a. Part1. Enter the disease, or	complications t	hat caused	the death.	Do not ente	er the mode of d	vina, such	as cardiac	or respiratory	arrest.	-	Approximate
1		shock, or heart failure. List Immediate Cause (Final	only one cause	on each lin	Θ.								Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)			neumo								
Examiner			Due	e to (or as a	a conseque	ince of):							
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that that ed by deta		Part II. Other significant condition	ons contributing	to death bu	ut not result	ing in the ur	nderlying cause o	jiven in Pa	art I.	23e. Did	tobacco	use contribute to	the cause of death?
sign d be	d by	Hypertension,	Dementia	<b>a</b>						1 🗆	Yes 2	□No 3□Pr	obably 4 Hunknown
Shounds	Completed						-			24a. Wa		24h Word ou	utongu findinga ayaylabla
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this al dir	2	1 ☐ Yes 2 🔀 No  27. Manner of Death		1 K Inpatie			C 3 L DOX	*-	Nursing He			6 ☐Other (Spe	city)
E g e e	lo lo	1 ⊠Natural 5 ☐ Pendir	ng (	Date of Injur Month, Day	Year)	8b. Time of Injury	W	ork?		28d. Describe	now inju	iry occurred	
Attending or death.	cat	2 Accident investi 3 Suicide 6 Could	not be	No. 20 24 1-1-		4- 1-		Yes 2	: UNO	006 1	/C4	- 1 11	-10
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificete has been signed by the attending to the Funeral Director. After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: Te Examiner: On the and	o the best o he basis of manner sta	examinatio	eage, death on and/or inv	occurred at the estigation, in my	opinion,	and place, death occur	and due to the red at the time	, date an	d place, and due	to the cause(s)
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10		▶ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	NIM	you	X		D6	35 <b>7</b> 9			July	y 28, 20	006
10		30. Name and address of person	who completed	cause of de	eath (Item 2	23a) (Tyne	Print)			•			
		Maria Tayag, M		00 For	est 0	Glen F	Road, Si	lver	Sprin	ng, MD	2091	0	
Sta Registr		31. Date filed (Month, Day, Year)	1 2006	32. Régistra	ar's Signatu	re 4	certi						

06-05813 Bruce E. Florimbio

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	ate of	Death			Re	eg No	100	6 2568
Physici	an/	1. Decedent's Name (First, Midd								Date of Dea Month	Day Y	ear	3. Time of Death
Medical Exami		Bruce Eugene F.					4h City Tayya	and meeting		August 5,	2006 4c Count	u of Death	2340 hrs
		4a. Facility Name (if not institution Frederick Memorial H		d number)		ľ	4b. City, Town, Frederick		or Oeain		Freder		I
Funeral		5. Social Security Number	6. Sex	7. Age (II	n yrs last birt	hday)	If Under 1 Y		er 24Hrs.	8. Date of Bir	th (MM/DD/YY)	YY) 9 Bir	thplace (State or
Director		218-90-0126	1 X M 2		43	Yrs		ays Hour	s Min.	06/02/	/1963	Foreig Co	Washington, DC
any	}	Usual Residence of Decedent  10a. State 10b County		110	c. City, Town	or Locat	ion						10d Inside City Limits
* .			lerick		-	eder							1 Yes 2 X No
Aaryland 28a-f show 1 at once.	용	10e. Street and Number	lel ICK		I. I.	euei	10f. Zip Code	e		1	0g. Citizen of \	What Coul	ntry?
th the Maryland 23a or 28a-f sho notified at once.	Director	5021 Saint Sim	on Court					21703			Unite	d Sta	ates
with the 18 23a e noti		11. Marital Status		Decedent Eve	er in U.S.		s Decedent of	Hispanic Ori					ican Indian, Black,
leath r iten	Funeral	1 Never Married 2 XXV	lairieu	ed Forces?	No	If Y	es, specify Cul	oan, Mexicar	n, Puerto R	ican, etc.)	Wh	nite, etc	
after (	by F	3 Widowed 4 Div	vorced If Yes, Give or Dates.			1	Yes 2X	No specify	:		Specify	w Whit	te
0036 within 72 hours afte iene. er than "natural", Medical Examiner		15. Decedent's Education (Spe					it's Usual Occu ost of working				16b Kind of I	Business/I	industry
36 in 72 han "	Completed	Elementary/Secondary (0-12)	Colleg	ge (1-4 or 5+) 5	Co	mnut	er Con	cultar	. +		Thform	ntion	n Technology
-00, 1 with giene ther the	E	17 Father's Name (First, Middle	Last)			трис	er con			First, Middle, I	Maiden Surnan		. recimorogy
21215-0036 uld be filed within 7 Mental Hygiene. marked other thau	Be C	Louis Florimbi						Mar	gare	t O'Bri	Len		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once		19a Informant's Name/Relations	ship (Type, Print	)	19	b. Mailing	g Address (St	reet and Nur	mber or Ru	ral Route Nun	nber, City or To	own, State	, Zip Code)
MD 2 shouth and m 27 is a		Michelle Flori	mbio / W	/ife							ck, MD		
		20a. Method of Disposition  1 XBurial 2 Crematio	n 3 Remov	al from State			ition (Name of her place) haven	cemetery,	1	Date ist 12,	20c. Location	n - City or	Town, State
트 집 원 등 등		4 Donation 5 Other S		ar work oraco		rial	_ Garde:		2	006	Freder	rick,	Maryland
Baltim permit Pag Department Important: injury or or		21. Sig and ral Service	e Li ee	_		Res	lame and Addr	ess of Facilit Funer	al Se	ervices	s, Skko	t Coo	dv P.A.
		23a Part I. Enter the disease,	r amplications th	et sourced the	dooth Oo n	1950	)l Cato	ctin M	ftn. I	Twv. Fr	rederic	k. MI	21701 Approximate Interval
Physician /Medical		failure. List only one cause	e on each line.						Darqiac or i	capitatory arr	Cot, Shook, Or i	icart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		as a consequ		trem	ity injur	ies					- Boutin
		Sequentially list conditions,	b		,								
	<u>ne</u>	if any, leading to immediate cause. Enter Underlying Cause		as a consequ	ence of):								
	Examine	(Oisease or injury that initiated events resulting in death) Last	C	as a consequ	ence of).								-
(0, e be executed ysician and burial - transit			d										
be exe ician a	n/Medical	X UNPENDEO	AMEND	ED item	#23a.27.	28a-f	perME.g	859.9/1	5/06 T	т			
8760, ifficate be ng physic	/We	IF FEMALE: 23b Was decedent pregnant in t	- i	yes, outcome	of pregnancy		,,				23d. Date		
certif	ciar	past 12 months?		ive birth regnant at tim			tal death	3 Ectob	ic pregnan	су	Month	Į.	Day Year
Box 687 ne death certific the attending p	Physicia	1 Yes 2 No 9 Ur	nknown 9 L	Jnknown			rici (opeany)						
.O. nat the ed by t	by Pf	Part II. Other significant condi	tions contribut	ing to death bi	ut not resultin	g in the u	underlying caus	se given in P	art I.				the cause of death?
s, P.C iires that 1 signed d be dete	q p												bably 4 Unknown
cords law requals been 2 shoul	plet									24a. Was autop	sy	prior to d	utopsy findings available completion of cause of
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the fact death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed									1 <b>V</b> Yes	rmed? 2 No	death? 1 ✓ Ye	es 2 No
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?					26.PI	ace of Death	(Check or	nly one)			
F Vil Physic or this	은	1 ✓ Yes 2 No	Hospital: 1		2 🗸 ER/O			Other <sub>4</sub>		Home 5	Residence 6		r
n of ding Ph		27. Manner of Death  1 Natural 5 Per	all as as	Date of Injury Month, Day,Year		Time of I		njury at Wor	_		how injury occi		
SiO Atten r deatl ector: by the	cati	2 X Accident Inve	estigation 4/	/19/2006		:07 an	n et, factory, offic	Yes 2			of auto i		Lision ural Route Number, City
Division pital or Attent ours after death eral Director: filled in by the	Certification;		ild not be		ghway	,	-, ,,			or Town, S	State) <b>I-7</b> 0	New M	arket, MD
Hospir 4 hou Funer ely fil		20a Cartifor	Physician: To the			ath occu	rred at the time	, date and p	lace, and d	lue to the caus	se(s) and manr	ner as star	ted
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Cricch oray	aminer:On the b	-	_								
5 7 % J	Me	29b Signature and title of certifi					29c. Lic	ense numbe	r		29d Date si	gned (Mo	onth, Day, Year)
		Polarial	Trans	- Pa	Colo a	~0	О.	C.M.E.			August 6	, 2006	
		30. Name and address of perso											
7		Patricia Aronica-Polla		sistant Med			111 Penn	Street, B	altimore	, MD 2120	1		
S Regis	tate trar	31. Date filed (Month Page e	9 2006 <sup>3</sup>	2. Ruistrar's	Signature	1	and a						
Negis	utell					19							

			1 - For Stata Registrar	State o	f Maryland		artment rtificate				-	giene Rag. No	211	06	25	681
			1. Decedent's Name (First, Middle,	Last)							2. Date of De				3. Time	of Death
	Physici /Medi		Thomas Joseph	Gordon							Month July 2	25, Da		Year	8:30	р м
	Examir		4a. Facility Name (If not institution,	give street and nun	n <i>ber)</i>		4b. City,	Town, or	Location of	of Death		4c	. County o	of Death		
			Montgomery Vil	lage Heal	th Caro	Conto	~ Mo	n+~-	. m o 2477	77477				36		
	Funeral			S. Sex	7. Age (In yrs. las		If Under	1 Year	If Under		8. Date of Birt	th		9. Birth	gomer place (State ptry)	or Foreign
	Director		391-34-4572	1 <del>Q</del> M 2 □ F	68	Yrs.	Months	Days	Hours	Min.	Month, Da uq. 17				otry) (Consi	
	Ď.		Usual Residence of Decedent		- 00						ug. II	, 1	/5/	****	CONSI	.11
	how		10a. State 10b. County		10c. City, T	Town or Lo	cation							1	0d. Inside (	City Limits
	B Ma	Director	Maryland I	Montgomer	У	P	ooles	vil1	.e						1 🗌 Ye	s 2. No
	5 28 P	ire	10e. Street and Number				10f. Zip					10g. Cit	izen of W	hat Cou	ntry?	
	within 72 hours after death with the Maryland ene. then 'naturel', or items 23s or 28e-f ehow ha Mailgal Exhibiter must be notified at		19405 Wootton	Avenue			208	37					US	A		
	dead	Funeral	11. Marital Status	12. Was Dece	ident Ever in U.S.	13.	Vas Decede	ent of His	spanic Ori	gin? (Spec	ify Yes or No	-	14. Race	- Americ	an Indian,	
9	or Its	Ē	1 ☐ Never Married 2x Marrie		2 🗌 No		f Yes, speci			i, Puerto P	lican, etc.)		Black	, White,	etc.	
සි	E	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	eates:1956-9	7	I□Yes 2	k⊈ No	Specify:				Specify:	Whi	.te	
21215-0036	72 hc	Completed	15. Decedent's (Specify only highest		1	6a. Deced	lent's Usual	I Occupa	tion			16b. K	ind of Bus	siness/In	dustry	
21	E .	ple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. I	kind of work DO NOT use	e retired)	uring mosi	t or working	g					
21	gien i	Ю		5+	,	Mil	itary	Off	icer				ted <del>red F</del>			
ď	S H	Bec	17. Father's Name (First, Middle, La	est)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame	) Orce	15	
Maryland	Aenta Aenta IIC e	10	Thomas Gordon						Maı	rgare	t Clar	k				
a <sub>Z</sub>	sho man		19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rural	Route Numbe	er, City o	r Town, S	state, Zip	Code)	
Σ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 Ie marked other then "naturel", or items 23a or 28e-f ehow other treumatic event, the Marsical Exhibition must be notified at		Maria E. Gordor	ı/ Wife	1	19405	Woott	on A	venue	e, Po	olesvi	lle,	MD	2083	7	
ē,	f He Item	l j	20a. Method of Disposition		000	e of Dispo	sition (Name	e of	. 1	Da	22,	20c. Lo	ocation - C	City or To	wn, State	
altimore,	permit. Pages Department of H Important: If Ite any Injury or of		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		ational			Aug.	•	7~1:	nata	<b></b> 17		
₫	artm ortan		21. Signature of Funeral Service Li	• • • • • • • • • • • • • • • • • • • •	1222				-						irgin	la
B	Depa Depa Impo any I		1	On Co		FT.	ancis O Uni	J.	COIII	ins F	uneral W, Si	Hom	e In	c.	MD 20	001
			23a. Part1. Enter the disease, or co	omplications that ca	sused the death. I								- Spr	ing,	Approxima	
			shock, or heart failure. List or Immediate Cause (Final	nty one cause on ea	ach line.			o. c,g	, 020 20	02.0.20 01	roopiiatory at	1031,			Interval Be Onset and	tween
de la	Physician /Medical		disease or condition resulting in death)		ol Cirrho		of Li	ver								
	Examiner		, , , , , , , , , , , , , , , , , , , ,		or as a consequen											
		_	Sequentially list conditions,	D	ary Arter		sease									
	sit ed	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	10	or as a consequen	CB OT):										
	and -tran	Examiner	that initiated events resulting in death) Last	c	tension											
60,	cien cien	Ω E		0 01 600	or as a consequen	CB OT):										
8760,	cate be executed physicien and the burial-transit	dicai		d										-		
9 X	ing p	Me	IF FEMALE:		V 500 11 50									- 10		
90	ath c ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	1☐Live bi	come of pregnancy	ath 3	Ectopic pre	gnancy				2	23d. Date		,	
<u>.</u>	e de:	Sic	1 ☐ Yes 2 ☐ No	4□Pregna 9□Unkno	ant at time of death wn	n 5 🗌	Other (spe-	cify)					Mont	n	Day	Year
P.O. Box	The law requires that the death certifications the been signed by the ettending page 2 should be detached for use as	by Physician/Me	9 Unknown													
Ś	igner bed	þ	Part II. Other significant condition	s contributing to de	ath but not resultin	ig in the ur	derlying ca	use giver	n in Part I.		23e. Did to	bacco u	se contrib	oute to th	e cause of	death?
ב	w requir been si should	Completed									1 O Y	es 2[	□No 3	☐ Prob	ably 4 🛣	Unknown
ပ္ပ	lawr 8 be 2 sh	pie									24a. Was a		24b. W	ere auto	sy findings	available
œ	The The ete he	E									autop perfor	med?	de	ath?	npletion of a 2□ No	ause of
Division of Vital Records,	Attending Physicien: Thirdeath. It death. Sctor: After this certificate by the funeral director, pag	a)	25. Was case referred to medical						26. Place	of Death (	Check only or	24.00		7 192	2   NO	
<b>&gt;</b>	<u>×</u> ∞ 5	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2 ER/	Outpatient	3□ DOA	Other			5 ☐ Resid		Other	(Specifi	,1	
0	ing Pt ter th	Ë	27. Manner of Death	28a. Date o	f Injury 28i	b. Time of	28	c. Injury			d. Describe h				/	
ō	e fc A	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		, Day (Gai)	Injury	м		es 2 🗆 N	10						
<u> </u>	Atte	뜵	3 Suicide 6 Could no 4 Homicide determine	ad 289. Place	of Injury - At home	, farm, stre	et, factory,	office		28	f. Location (S	treet and	d Number	or Rura	Route Num	ıber,
ā	s afte	Certification:	- Gramaia	buildiri	g, etc. (Specify)						City or Tow	n, State,	,			
	hour hour inere		29a. Certifier 1 Cartifying	Physician: To the I	best of my knowled	dge, death	occurred at	t the time	, date and	place, an	d due to the c	ause(s)	and manr	ner as st	ated.	
	ne Ho	Medical	(Check only 2 Medical Ex	aminer: On the ba	sis of examination	and/or inv	estigation, i	n my opi	nion, deat	h occurred	at the time, o	ate and	place, an	d due to	the cause(s	3)
	To the Hospital or Attending Phymitin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Ž	29b. Signature and title of certifier	/				License			Z	9d. Date	e signed (	Month, L	Day, Year)	
			+ HUA	aller	-		1	05642	20		-	July	y 27,	200	06	
(	0+1		30. Name and address of person wh	o completed cause	of death (Item 23	a) (Tvna F	Print)						_			
		3	Humera Malik, M		19 Doctor		,	Germ	antow	vn, M	D 2087	4				
	Sta	te		32, Fie	gistrar's Signature	1	100			•						
	Registr		AUG 0 1	2006	gree St.	FIOR	Mary Sand									
			MUU V L	-		77										

ID

30 Name and address of person who completed cause of death (Item 23a)

2006

Assistant Medical Examiner

32 Registrar's Signature

GRENE

Pamela Southall, MD

31. Date filed (Marth Gy,

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 28, 2006

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0130 AM July 27 BRONYA GOLOBORODKO 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 1XE 76 Yrs. DEC 25, 039-62-5993 UKRAINE Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County rai', or Itama 23a or 28a-f show Examiner must be notilized at MARYLAND MONTGOMERY DERWOOD 1X Yes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16125 CRABBS BRANCH WAY APT.21 20855 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) NURSE MILITARY HOSPITALS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is 1 and 2 should be fill of Heelth and Mental H Itam 27 is marked off Be ALIK MOLDAVSKY ANNA KRASNOPOLSKYA ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISRAEL GOLOBORODKO-HUSBAND 16125 CABBS BRANCH WAY APT.21, DERWOOD, MD 20855 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any injury or once. GARDEN OF REMEMBRANCE 07/28/2006 CLARKSBURG, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neu monia /Medical Due to (or as a consequence of): Examiner troke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Ą 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No certificete 1 Yes 1 ☐ Yes 2 No of Vital To the Hospital or Attanding Physician: "within 24 hours efter death.

To the Funeral Diractor: After this certifice completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 1 ☑Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 1 Natural Division 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 July, 27, 64415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. NIMESH SATISH SHAH, 330 BROOKLINE AVE, BOSTON, MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 01 2006 Registra

## Please Type or Print in Black Indelible Ink

e Eugene		1-For State Amend #4a&b&26 Per ME Certificate of			o. 200	5 2568
Physicia cal Exami		1. Decedent's Name (First, Middle,Last) Ronnie Eugene Garner		2. Date of Death Month Day July 24, 2006		3. Time of Death 2240 hrs
		4a Facility Name (if not institution, give street and number) 4700 Alabama Avenue Prince George's Hosp Center	4b. City, Town, or Location of Death Washington, DC Cheve		4c. County of Deat Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  1 N 2 F 17 Yrs	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.		M/DD/YYYY) 9. Bi	
ny.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	iion			10d. Inside City Limits
ith the Maryland  23a or 28a-f show any notified at once.	<u>_</u>	DC Washingto	on			1 XYes 2 No
Maryla · 28a-f ed at or	Director	10e. Street and Number	10f. Zip Code	l o	Citizen of What Cou	
filed within 72 hours after death with the Maryland I Hygiene ed other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once		324 34th Street SE #4  11. Marital Status	20019 as Decedent of Hispanic Origin? ( Sp.		Inited Sta	ates rican Indian, Black,
leath w r items	Funeral		es, specify Cuban, Mexican, Puerto		White, etc.	Today Malay Diagra
s after c ral", o	ক্র	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:	carle dans 16h	Specify: B1:	
2 hour "natu	eted		nost of working life DO NOT use retir		o. Kind of Business	rindustry
be filed within 72 ntal Hygiene rked other than ent, the Medical	omple		ıdent		nemploye	d
permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Be Co	17. Father's Name (First, Middle, Last) Ronnie E. Miles		(First, Middle, Maide Garner	en Surname)	
ould be d Ments s mark iic even	To B	19a. Informant's Name/Relationship (Type, Print )	g Address (Street and Number or R	Rural Route Number,		
es I and 2 show of Health and If item 27 is ther her traumation			34th Street SE #		c. Location - City or	
permit Pages I are Department of Her Important: If ite ujury or other tr		1 X Burial 2 Cremation 3 Removal from State crematory or of	ther place)	1/06		
permit Pag Department Important: injury or ot		4   Donation 5   Other Specity.	Name and Address of Facility AUS	,	Suitland er Innera	
perr Dep Imp	J	7/9/2	3821 14th Street		,	20011
hysician Medical		23a Part I. E. er the disease, complete a Caused the death. Do not enter the failural ist only one caus on each line.	the mode of dying, such as cardiac or	r respiratory arrest, s	shock, or heart	Approximate Interval Between Onset and
xaminer	NII Y	Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wounds of Head  Due to (or as a consequence of):			•	Death
	L	Sequentially list conditions, b		,		
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				1
ed nsit	Exar	events resulting in death) Last Due to (or as a consequence of):				
ate be executed hysician and e burial - transit	ical	JUNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Female Pregnant at time of death 5 0 0 9 Unknown  9 Unknown  contributing to death but not resulting in the				
cate be physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		1	23d. Date of deliver	,
he death certificat y the attending phy hed for use as the	cian	past 12 months?  1 Live birth 2 Fe 4 Pregnant at time of death 5 0	etal death 3Ectopic pregna ther (Specify)	incy	Month	Day Year
ne death c the atten ned for us	hysi	1 Yes 2 No 9 Unknown 9 Unknown		Too. 51.11.1		
ires that the signed by the detached	_ <u>⊙</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?  bably 4 Unknown
ng Physician: The law require After this certificate has been si nneral director, page 2 should b	Completed			24a. Was an		utopsy findings available
The law cate has page 2 sh	ldmo			autopsy performed 1 ✓ Yes 2	? death?	completion of cause of
certificate ector, page	Be C	25. Was case referred to medical	26.Place of Death (Check of			
Physici r this c al dire	To E	examiner?    Wyes 2   No   Hospital: 1   Inpatient 2   ER/Outpatient   Respectively.		ng Home 5 Res 28d. Describe how	idence 6 Othe	er: Scene
ending Ph eath or: After the funeral	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of 1 Natural 5 Pending Jul 24, 2006 0910 hrs		Subject shot	injury occurred	
tal or Attendings as after death al Director: A led in by the fu	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At home, farm, stre	eet, factory, office building, etc.			ural Route Number, City
pital or ours afte eral Dir filled in	Certi	4 🗸 Homicide determined (Specify) Sidewalk		or Town, State 4700 Alabama		Vashington, DC
Hos 24 h Fun	g	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occur (Check only 2 Medical Examiner: On the basis of examination and/or investigation.)	urred at the time, date and place, and ation, in my opinion, death occurred a	due to the cause(s)	and manner as sta	rted. he cause(s)
To the within To the complex	Medi	and manner stated  29b Signature and title of certifier	29c. License number		d Date signed (Mo	
		( X De Vole W)	O.C.M.E.		uly 25, 2006	,
/		So Name and address of person who completed cause of death (Item 23a)				
-3			n Street, Baltimore, MD 212	01		
	itate strar	PULLS II I / IIII   MERCALA A AA' MARK	West of the second			

•	1 - State Registrar	State of Marylar	-	ertificate			g. No. 200	6 256
	1. Decedent's Name (First, Middle, Last,	t)				2. Date of Deat	h Day Ye	3. Time of I
in al	Louise	М.		Garla	and	duly.	30,200	
er	4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	wn, or Location of Dea	th 9	4c. County of D	eath
	SALISBURY REHAB &				BURY, MD.		WICOM	ICO Birthplace (State or
	5. Social Security Number 6. Se	7. Age (In yrs. ☐ M 2X F 93	. iast birtnda Yrs.		ays Hours Min	8. Date of Birth (Month, Day,	Year) 1013 Nor	country)
	237-26-5320 Usual Residence of Decedent	75				reb. 1,	1913 101	cii carori
	10a. State 10b. County	10c. C	ity, Town or	Location				10d. Inside City
to	MD Worceste	er F	Berlin					1 X Yes
Funeral Director	10e. Street and Number			10f. Zip Co	ode	1	0g. Citizen of What	t Country?
0	10907 Player Lane			21	1811		USA	
ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13	3. Was Deceden	t of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No-		American Indian, Vhite, etc.
	1 Never Married 2 Married	1 ☐ Yes 2 No		1 ☐ Yes 2X		, , , , , , , , , , , , , , , , , , , ,	Specify: \	
a by	3 Midowed 4 ☐ Divorced	Year or Dates:						
Completed	15. Decedent's Edu (Specify only highest grad		(Giv	cedent's Usual C	done during most of w		16b. Kind of Busine	ess/Industry
ďμ	Elementary/Secondary (0-12)	College (1-4or 5+)		. DO NOT use i	,		Shirt Fac	tory
	12 17. Father's Name (First, Middle, Last)		1 30	eamstres		ame (First, Middle, M		LOLY
Be						e Byrd		
မ	William McKinney  19a. Informant's Name/Relationship (T)	Type Printl	19h Ma	iling Address (S	treet and Number or F		City or Town Star	te. Zip Code)
	Linda Carol Busick				er Lanes,			.0, 2.6 0000)
	20a. Method of Disposition	20b.	Place of Dis	position (Name	of		20c. Location - City	or Town, State
	1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	cemetery, c	rematory or othe	r place)	1 06 1	Delmar, D	\₽
	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens				Lmarva † 7–3 Address of Facility			
	21. Signature of Pulletar Service Cicents	born RAMO			Main Street			ie
S ()	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	clications that caused the dea	ath. Do not e	enter the mode o	of dving, such as cardi	ac or respiratory arri	est,	Approximate
	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.		_	, ,	·		Interval Betw Onset and D
	disease or condition resulting in death)	Dena	10					coan
		Due to (or as a conse	quarica oi).	- ^ ^			,	
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. to ras a cons	uence of):	no con				10000
amin	Cause (Disease or injury	Colored	10	1. lko	Nen-			year_
Exa	that initiated events resulting in death) Last	C. Due to (or as a conse	q nce of):					7
		d						
edicai					68			
Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		2 🗆 Eata-i			23d. Date of	delivery
cla	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of		3 □Ectopic preg 5 □ Other ( <i>speci</i>			Month	Day Y
hys	9 🗆 Unknown	9□ Unknown				-		
by P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the	underlying caus	se given in Part I.			te to the cause of de
						1 □ Y	s 2 10 3	Probably 4 U
6						24a. Was a	n 24b. Wer	e autopsy findings a
pleted						autops perfor 1 \(\sum \) Yes	ned? deat	r to completion of ca th? Yes 2□ No
ompleted		Manager and the second			26. Place of D	eath (Check only on		
e Completed	25. Was case referred to medical		☐ ER/Outpat	tient 3 DOA	Other	Home 5 ☐ Reside		Specify)
o Be	examiner?	Hospital: 1 Inpatient 2					ow injury occurred	
To Be	examiner? 1  Yes 2 No  27. Manner of Death	1 L Inpatient 2L	28b. Time	e of 28c	Work?			
To Be	examiner? 1 Yes 2 No	28a. Date of Injury (Month, Day Year)		a of 28c y M	: Injury at Work? 1 ☐ Yes 2 ☐ No			
To Be	27. Manner of Death  1 PATURAL 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time Injur	М	1 ☐ Yes 2 ☐ No			or Rural Route Numb
To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time Injur	М	1 ☐ Yes 2 ☐ No	28f. Location (Si City or Town		or Rural Route Numb
Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Accident	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Specials: To the best of my kr	28b. Time Injury home, farm, bify)	M street, factory, c	1 ☐ Yes 2 ☐ No  office  the time, date and pla	City or Town	n, State) ause(s) and manne	er as stated.
o Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Accident	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Spec	28b. Time Injury home, farm, bify)	M street, factory, c	1 ☐ Yes 2 ☐ No  office  the time, date and pla	City or Town	n, State) ause(s) and manne	er as stated.

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

200 CIVIC AVE., SALISBURY, MD. 21804
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D.
31. Date filed (Month, Day, Year)

AUG 0 1

			For State Registrar	State of Marylan		artment of I			giene Reg. No.	06	25689
ı			1. Decedent's Name (First, Middle, Las	it)				2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		Norma Lee Gott					July 3	0, 200	6	6:30 P. M
3	Examin		4a. Facility Name (If not institution, give	street and number)			or Location of De	eath .		nty of Death	
			8495 Mackall Road			St. Leo		1		vert	
	Funeral Director		220-26-6891	ex	last birthday) Yrs.	If Under 1 Year Months Days		lin.   8. Date of Bir (Month, Date of Bir Dec 23	th ay, Year) B <b>,</b> 1929	9. Birthp Cour Mary	place (State or Foreign http) rland
	and **		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl f sho	ğ	Ar1 Galaront	c+	Leona	rd					1 ☐ Yes 2 🛣 No
	r 28a	rec	Maryland Calvert  10e. Street and Number	, , , , , , , , , , , , , , , , , , , ,	135.10	10f. Zip Code			10g. Citizen	of What Cour	ntry?
	h with	Funeral Director	8495 Mackall Road			20685			United	State	es
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of I	Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)	o- 14. F	Race - Americ	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Items 23a or 28a-f show svent, the Modical Exactinat must be rigitled at	Š	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 MNo If Yes, Give Year or Dates:	1	1 □ Yes 2X No			Spe		
ئ ا	72 hc natu	etec	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	(Give	dent's Usual Occu kind of work done	during most of	working	16b. Kind of	Business/In	dustry
121	vithin ne. hen '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire uctional	,	n+	Public	s Saha	o1
N	filed wil Hygien other the		17. Father's Name (First, Middle, Last)		IIISCI	uccionai		Name (First, Middle	<u> </u>		OI_
an	d d d d	To Be	Guy Walter Wilbur				Blanch	e Violett	te Ogde	n	
<u></u>	2 should be and Mental ie marked o eumetic ev	ř	19a. Informant's Name/Relationship (	Rural Route Numb	er, City or Tox	vn, State, Zip	Code)				
Ž	1 and 2 Health a tem 27 le		Donna Gott Nichol	ls (Daughter)	8525	Mackall	Road, S	St. Leona	rd, Mai	ryland	20685
e,	of Her of Her fitem r othe		20a. Method of Disposition	ICIamaval from Ctoto	cemetery, cre	osition (Name of matory or other pla		Date	20c. Locatio		
altimore,	Pages nent of I ant: If its ury or o		f Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Wat	ers Me	em. UMC C	Cem. 8/0	2/2006			, Maryland
Balt	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 ie marke any injury or other treumetic.		21. Signature of Funeral Service Licen	nsee	44	2. Name and Addr 105 Broomes	ess of Facility SISLAND R	Rausch Front Food, Port F	merai Republic,	Home, Maryla	P.A. and 20676
i			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec		<u>_</u> <u></u>	REAS	TCAN	1651		
T	Examiner	-	Sequentially list conditions.	b. Due to (or as a conseq	mence of:						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	querice or,						
	be executed Sician and burial-transit	Exar	that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of):						
760,	w ~ w	cal		d				****			
89			IE ESMALE.								
Box	death certifica e attending ph ed for use as th	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	al death 3[	⊒Ectopic pregnand	су		23d.	Date of deliver	ery Day Year
0	0 0 0	Physiclan/Med	1 ☐ Yes 2 5 No 9 ☐ Unknown	4□Pregnant at time of c 9□Unknown	death 5 (	Other (specify)					
α.	The law requires that the de ate has been signed by the a bage 2 should be detached f	'Ph	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	ınderlying cause g	ıven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
Records,	uires tha signed Id be det	d by						10	Yes 2 No	3 ☐ Prot	oably 4 DUnknown
S	w require been significant	Completed						24a. Was		b. Were auto	ppsy findings available
Re	The la te has age 2	omp						— auto perf 1 ☐ Yes	ormed? 2 No	death?	impletion of cause of
ā	ien: Trifica	· O	25. Was case referred to medical				26. Place of	Death (Check only			
>	Physicien: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA	ther: 4 🗆 Nursin	ng Home 5 Res	idence 6 🗆	Other (Specia	(y)
0 [	ng Pł		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W		28d. Describe	how injury oc	curred	
<u>S</u>	Attending ir death. octor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b				Yes 2 No	29f Location	(Stroot and No	mhar or Pur	al Route Number,
Division of Vital	after of Direct	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, tarm, st	reet, factory, office	•		own, State)	iniber of Mur.	ai Aoble Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C		nysician: To the best of my kno miner: On the basis of examina and manner stated.							
	o the	Mec	29b. Signature and title of certifier	7		29c. Licer	nse number		29d. Date sig	ned (Month,	Day, Year)
	⊢≯⊢ŏ		PATA	i sm		D 4	0370		7/3/	106	
	•		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type		/ -		1-1	1-/	
_	10		Peter L. Wisniews	ski, MD 110 Ho	spital	Road, St	uite 310	), Prince	Freder	ick, N	1D 20678
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra & Sign.	ature	Sperke					
	TICGIS!	1	HUU		-41						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** illiam gaines 06 10:04 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tracy's Landing Anne Arundel 505 Club Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y June 23, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** , 1938 1**⊠**M 2□F Wash., Yrs 68 D.C. 577-50-7409 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits in then "naturel", or Items 23a or 28e-f show It e Medical Examiner must be notified at 1 ☐ Yes 27 No Director Anne Arun**de**l Tracy's Landing 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20779 **USA** 505 Club Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) carpenter Wash., D.C. Govt. 11 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fit and Mental F Elizabeth Catherine Craig Eston Gaines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 505 Club Road, Tracy's Landing, MD 20779 Barbara J. Gaines, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I permit. Pages
Department of Importent: If it eny injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 08-02-06 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Willian Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final nonsmall cel ung cancer **Physician** disease or condition resulting in death) 7\_mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician by Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? for us 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1X Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 X No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending investigation death, 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Intury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Hospital Octifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title, of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059173 10 cause of death (Item 23a) (Type, Print) SESTEME Rd. Suite 300 ANNAPOUS 31. Date filed (Month, Day, Year) State AUG Registrar

Charles George, Sr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 25691

		1- For State Registrar			Certific	ate of	Death			Reg No	6. (	ا ل اي	1 600	)
Physicia		Decedent's Name (First, Min	Sr.		2. Date of D				<ol><li>Time of Death</li></ol>					
edical Exami		Charles		Vernon			George		Month August	7, 2006	Year		1210 hrs	
		4a. Facility Name (if not institu	ition, give street an	d number)			c. City, Town, or Le	ocation of Death	1	4c	County o	f Death		
		Potomac River at er	nd of Wills Cre	ek		1	Cumberland			A	Allegany			
Funeral		Social Security Number	6. Sex	7. Age (In	yrs last bin	thday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of	Birth (MM/	DD/YYYY)		place (State or	_
Director		218-62-6155	197				Months Days	Hours Mir	03/0	C / 1 O E		Foreign	Maryland	
			1 X M 2	F 51		Yrs.			03/0	6/195	) )			_
any	-	Usual Residence of Decedent  10a State 10b, Coun	tv	10c	City, Town	or Locatio	n			-			10d Inside City Limit	ts
#			,	100.	Oldy, Town								1 X Yes 2 N	
yland -f sho once.	ō		llegany			Cur	mberland							
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number					10f. Zip Code			10g Citi	zen of Wh	at Coun	ry?	
th the Mary 23a or 28a notified at		319 Bedf	ord Stree	et, Apt	. A		215	02			USA			
with ns 23	Funeral	11. Marital Status		Decedent Ever	in U.S		Decedent of Hisp			No-			an Indian, 8lack,	
leath r iter	šI	1 Never Married 2	Married 1 Y	ed Forces?	No	If Ye	s, specify Cuban,	Mexican, Puerto	Rican, etc.)	- 1	White	, etc		
fter o		3 Widowed 4 X	Divorced If Yes, Give			1	Yes 2 X No	specify:		- [	Specify:	В	ack	
urs a ntura amir	d by	15. Decedent's Education (S	pecify only highest	grade complete			s Usual Occupatio			16b H	Kind of Bus			
5-0036  ed within 72 hou tygiene other than "nat	Completed	Elementary/Secondary (0-1	2) Colle	ge (1-4 or 5+)		during mo	st of working life. [	DO NOT use ret	ired)					
thin the than	ldu	12		1		Ма	intenanc	е			Hote	1		
d wil	Ö	17. Father's Name (First, Midd	lle, Last)				18	8 Mother's Nam	e (First, Middl	e, Maiden	Surname)		-	_
e file e file ral H ced o	Be (	Unkn	own					Unk	nown					
21215-0036 Juld be filed within 7 Mental Hygiene marked other than	.0	19a. Informant's Name/Relation	onship (Type, Print	)	19	b. Mailing	Address (Street	and Number or	Rural Route N	Number, C	ity or Towr	n, State,	Zip Code)	_
O g E is if		Franklin Geo	rge / son	า		413 F	urnace S	treet,	Cumber	land	, MD	215	502	
- p + s = 1		20a Method of Disposition			20b. Place	of Disposit	ion (Name of ceme		Date		•	City or T	own, State	_
<u> </u>		1 Burial 2 X Cremai	ion 3 Remov	val from State	crema	tory or othe	er place)							
Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other			Cumb	erlan	d Cremat							
Baltin permit I Departm Importa injury o		21. Signature of Funeral Serv	ice Licensee	^			ame and Address	AU		-			Home, P.A	1.
		Xalt C	Adr	-/)		40	4 Decatu	r Stree	t, Cum	berla	and,	MD	21502	-1
Physician		23a Part I Enter the disease, failure. List only one cau	ise on each line	(/						arrest, sno	ock, or nea	art	Approximate Interv Between Onset an	
Medical Examiner		Immediate Cause (Final disea	ase a. Dro	wning con	plicate	ed by	alcohol in	toxicatio	n				Death	-
ZAGIIIIICI		or condition resulting in death	Due to (or	as a conseque	nce of):									
	_ ا	Sequentially list conditions,	b											
	Examiner	if any, leading to immediate cause. Enter Underlying Cad	se	as a conseque	nce of):									
	am	(Disease or injury that initiate events resulting in death) La	d C	as a conseque	nce of):				<del></del>		· · · · · ·			
ansit		evento resulting in dodding Ed	d											
8760, tificate be executed ng physician and as the burial - transitas the burial - transitas the burial - transitas the burial - transitas the burial - transitas the burial - transitas the burial - transitas -	n/Medical	X UNPENDED	X AMEND	ED .				250 2 /26	O					
30, ie be ysici	<u>e</u> q	IF FEMALE.	23c If	item# yes, outcome o	1.23a.	27,28a	-f.perME.g	859,9/26/	06 TT	23	d. Date of	delivery		_
<b>∞</b> ± 8 s	Ž	23b. Was decedent pregnant i	a Ala a	ive birth			al death 3	Ectopic pregn	ancy	120	Month	D	ay Year	
x 6 h cerl tendii	icia	past 12 months?		regnant at time	- f -l 4l-		er (Specify)			- 1				
P.O. Box 68 that the death certined by the attending detached for use a	Physicia	1 Yes 2 No 9	Unknown 9 1	Jnknown										
O. at the 1 by t		Part II. Otner significant con	ditions contribut	ing to death but	not resultin	g in the ur	nderlying cause giv	ven in Part I.	23e. Dr	d tobacco	use contri	bute to t	ne cause of death?	
, P.C.	g F								1	Yes 2	No 3	Prob	ably 4 🗸 Unknown	١
Records, P.O. The law requires that to frate has been signed by, page 2 should be detac	Completed								24a W				opsy findings availab	
Cor law r has b	힐								pe	itopsy erformed?		rior to co eath?	empletion of cause of	ı
Rec The I	5									s 2 N	lo 1	<b>✓</b> Ye	2 No	
tal Rection: The certificate ector, page	Be (	25. Was case referred to med examiner?						of Death (Check				_		_
Division of Vital tal or Attending Physician: Is after death all Director: After this certiled in by the funeral director	101	1 Yes 2 No	Hospital: 1	Inpatient		outpatient			ng Home 5		ence 6 🗸	_	Scene	
n of ling Ph After funeral		27. Manner of Death	28a	Date of Injury Month, Day, Year)	28b.	Time of In	′ ′	at Work?	28d Descri	be how inj	ury occurre	∍d		
ion tendi eath tor:	읉		ending rvestigation Fn	d 8/7/200	)6   Fn	d 11:5	0 am ¹	es 2 X No	subjec	ct dro	wned			
VIS or At frer d orec in by	<u>;</u> ≧	-	ould not be 28e.	Place of Injury	- At home, f	arm, stree	t, factory, office bu	uilding, etc.	28f Locatio	n (Street a	and Number	or Rur	al Route Number, Ci	ty
Divis pital or At ours after d ceral Direc	Certification:		etermined (Spe	ecify) Four	nd in b	ody of	water		of Wil	lis Cr	eek	. KTA6	al Route Number, Ci er at end	
Hosp 14 ho Fune ely fi		29a. Certifier 1 Certifying	Physician: To th	e best of my kn	owłedge, de	ath occurr	ed at the time, dat	te and place, an						
Division of Vital Records, P.O. Box 6 ro the Hospital or Attending Physician: The law requires that the death certwint of 24 thours after death completely filled in by the funeral director, After this certificate has been signed by the attention ocmpletely filled in by the funeral director, page 2 should be detached for use.	Medical	one) 2 Medical E	xaminer: On the b		ation and/or	ınvestıgatı	on, in my opinion,	death occurred	at the time, d	ate and pla	ace, and d	ue to the	cause(s)	
To To	Me	29b Signature and title of cer		ner stated			29c License	number		29d.	Date signe	ed (Mon	th, Day, Year)	_
		1/1 1	. 11	111			O.C.M	1.E.		Aud	gust 8, 2	2006		
		Massa Ker	assell.	MA	(1) 00 :									
		30. Name and address of per Melissa Brassell, M		cause of death Medical Ex		111 P	enn Street, Ba	altimore MF	21201					
				2. Registrar's S				animore, IVIL	1201					
S Regis	tate	7 0110	4 2006		ngi iatura	1	- M -							

ORIGINAL

06-05488 Dipash Giri

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	,	Death			Re	g. No.	1 U U	0 2007		
Physicia ledical Examin	n/	Decedent's Name (First, Middle,I	Last) DIPES	H GIR	RI			1	Date of Deat Month July 27, 20	Day \	/ear	3 Time of Death 2121 hrs
		4a. Facility Name (if not institution, Shady Grove Adventist	-		4	b. City, Town, Gaithersb		f Death			ty of Death omery	
Funeral	4		·	(In yrs. las	st birthday)	If Under 1 Y		r 24Hrs.	8. Date of Birt		YY) 9. Birt	hplace (State or
Director	-	N/A	1 XM 2 F	22	Yrs.	Months D	ays Hours	Min.	Unkno	wn	Foreig Cou	n untry) Nepal
any	F	Usual Residence of Decedent  10a, State 10b, County		10c. City, 7	Town or Location	on						10d. Inside City Limits
* .	ر پ	Maryland Montgo	omery		G	aithers	sburg					1 X Yes 2 No
Aaryland 28a-f slrow 1 at once.	Director	10e. Street and Number				10f. Zip Code	;		10	Og. Citizen of	What Cour	ntry?
th the Maryland 23a or 28a-f shu notified at once.		20 B Crestwood		_			877				epal	
ath wit	ன் I	<ul><li>11. Marital Status</li><li>1 X Never Married 2 Marr</li></ul>	12. Was Decedent E Armed Forces?	_		s Decedent of es, specify Cub			cify Yes or No- ican, etc.)		hite, etc.	can Indian, Black,
ifter de Il'', or	by Fun	3 Widowed 4 Divor	1 Yes 2 ced If Yes, Give Year	X No	1	Yes 2K	No specify:			Specif	fy.	Asian
hours a	eted b	15. Decedent's Education (Specific	y only highest grade comp College (1-4 or 5	,	16a Decedent during mo	's Usual Occu st of working l				16b. Kind of	Business/I	ndustry
136 hin 72 e than "	plet	Elementary/Secondary (0-12)  12	College (1-4 or 5	+)		Retai	1			CI	othin	ıg
5-0036 iled within 72 Hygiene tother than "	Comple	17. Father's Name (First, Middle, La	ast)				18.Mother		First, Middle, N		me)	-
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	To Be	Raj Kumar Giri 19a Informant's Name/Relationship			19b Mailing	Address (St	reet and Num		ara Gir		own. State	. Zip Code)
O & B is it	٦	Bhaskar Giri	(1)[-1]		1	,						g,MD 20879
re, land Healt Healt If item		20a, Method of Disposition  1 Burial 2 X Cremation	3 Removal from Sta		lace of Disposi rematory or oth		cemetery,		Date 1gust	20c. Location	on - City or	Town, State
Baltimore, permit Pages I am Department of Hea Important: If iten injury or other tr		4 Donation 5 Other Spec	cify:		thsbur			5,	2006			, Maryland
Baltimore, MC permit Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:	Į	21. Signature of Funeral Service Li		No14		ame and Addr						al Home land 21783
Physician		a. Part I. Enter the disease, or co	omplications that caused t	the death.								Approximate Interval Between Onset and
/Medical		failure. List only one cause of Immediate Cause (Final disease	a. Drowning								11	Death
		or condition resulting in death)	Due to (or as a conse	quence of	):							
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of	):							
1	αl	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a conse	quence of	):						<del></del>	
ecuted and transit	al Ex		d							-		
760, ficate be evecute g physician and the burial - tran	/Medical	UNPENDED  IF FEMALE:	X AMENDED iter  23c. If yes, outcom	n#1,2,	23a,PII,2	27,28a-f	,perME,g	861 1	.1/3/06 T	T 23d Date	e of delivery	/
687(ertifica	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fe		3 Ectopic	c pregnan	су	Month	n [	Day Year
Box 68 death certification and for use as I	Physician	1 Yes 2 No 9 Unkn	7	unte or de	ath 5 Oti	ner (Specify)						
P.O. Be res that the de signed by the be detached for	by Ph	Part II. Other significant condition	_	but not re	sulting in the u	inderlying caus	se given ın Pa	art I.		_		the cause of death?
S, P juires th	ed b	Paranoid Schizo	phrenia						1 Yes			topsy findings available
cords, taw requir	Completed								autop perfo	osy rm <u>ed</u> ?		completion of cause of
tal Rec		25. Was case referred to medical		•		26 P	ace of Death	(Check or	1 Yes	2 No	1 🗸 Ye	es 2 No
Vital hysician:	To Be	examiner?	Hospital: 1 Inpatie	nt 2	ER/Outpatient		Other <sub>4</sub>	<u>`</u>	Home 5	Residence	6 🗸 Othe	r: Scene
ion of tending Pheath		27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry ear)	28b. Time of I	· ·   _	Injury at Work		28d. Describe	how injury oc	curred	
Sion Attend r death ector: by the f	catic	- Fendi	rigation Fnd 7/27/ 28e. Place of In		Fnd 7:10	Pili	Yes 2 X		unknown	Street and Nu	imber of Ri	ıral Route Number, City
Division of Vital Records, spiral or Attending Physician: The law requir hours after death uneral Director: After this certificate has been so filled in by the funeral director, page 2 should the filled in by the funeral director, page 2 should be a set of the filled in by the funeral director.	Certification:	3 Suicide 6 X Could 4 Homicide determ	not be		Jille, Idilli, Sile	st, ractory, one	se building, et	- 4	or Town, S Saithers	State) Bohr	er Par	k
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Phy	ysician: To the best of my	y knowledg	ge, death occur	red at the time	e, date and pla	ace, and o	due to the caus	se(s) and mar	ner as star	ted
To the Hos within 24 h To the Fu	Medical		niner: On the basis of exar and manner stated.	nination a	nd/or investigat		nion, death oc ense number	curred at	the time, date			ne cause(s)
	2	29b. Signature and title of certifier	1/0				C.M.E.			July 28,		ining boy, roury
		30. Name ress of person	who completed cause of d	eath (Item	23a)							
		Pamela Southall, MD	Assistant Medical	Evamir	ner 111 F	Penn Stree	t, Baltimor	e, MD 2	21201			
St Regis	tate trar	D1 Un 1 G / UUD   170 a Maria 177 a										

			1 - For State Registrar	State of	Marylan			nt of Hea te of De	alth and N eath	/lental H	ygiene Reg. No	200	6 2569
			1. Decedent's Name (First, Middle, La	ast)						2. Date of I			3. Time of Death
	Physici		Dianne H. Gurley	У						Month July	28. 2	у <sup>Үөаг</sup> 2006	6:37 <sup>a м</sup>
1	/Medic Examir		4a. Facility Name (If not institution, gir	ve street and num	iber)		4b. City	, Town, or Loc	cation of Death			. County of De	
	LXamii	101	Montgomery Hospic	ce-Casev	House		Ro	ckvill	e			Montgo	merv
-	Funeral		J		7. Age (In yrs.	last birthday)	If Unde	r 1 Year   If	Under 24 Hrs.	8. Date of I	Birth	9. B	rthplace (State or Foreign
	Director		097-28-4968	1 □ M 2430.F	69	Yrs.	Months	Days H	lours Min.		Day, Year) 193		ountry) W York
			Usual Residence of Decedent				1			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
	ylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	the Marylar 28a-f show	tor	Maryland Monto	gomery	9	Silver	Spri	na					1 ☐ Yes ¾ ☐ No
	h the	lre	10e. Street and Number		,		-	p Code			10g. Cit	tizen of What (	Country?
	h wit	a 0	13101 Hathaway	Drive			2	0906				USA	
	deed	by Funeral Director	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Dece	edent of Hispa	inic Origin? (Sp Mexican, Puerto	pecify Yes or I	No-	14. Race - An Black, Wh	
9	or Ite	F	1 ☐ Never Married 2∑Married	1 Tes	<b>℃</b> No		irres, spi 1 ∐ Yes		Specify:	riioari, etc./		Specify: Wh	_
8	ral',	by	3 Widowed 4 Divorced	Year or Da	ites:		1 🗆 165	2 <b>6</b> 1 NO 3	рөспу.			Specify: WII	100
21215-0036	within 72 hours after deeth with the Maryland ene. then "netural", or Iteme 23a or 28a-f ehow he Madigal Exertainer must be codified at	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Deced	dent's Usu	ual Occupation	n na most of work	kina	16b. K	ind of Busines	s/Industry
2	We e	nple	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	ise retired)	ng most of work	9			
2	Agien Per th	Con	12			Homem	aker				<u> </u>	Own H	ome
p	a H H	Be	17. Father's Name (First, Middle, Las	•					. Mother's Nam			Sumame)	
Va	Ment	2	Louis C. Hartra	nit					Christi	ne Cla	rke		
Maryland	and and le m		19a. Informant's Name/Relationship						Number or Rui				
Σ.	and salth		Revere W. Gurley	// nuspai					Drive,			<u> </u>	MD 20906
e C	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		20a. Method of Disposition to Burial 2 ☐ Cremation 3 [	"I Domoval from 9		Place of Dispo cemetery, crer	nsition (Na matory or	me of other place)		Date Just 14		ocation - City o	r Town, State
Ĕ	8 1 1 2 X		4 Donation 5 Other (Special		Arl	lingtan 1	Nation	al Ceme	tery	2006		ington,	Virginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylau Department of Health and Menial Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-1 show early injury out-pher treumatic event, the Madical Exercitar natural be redifficed and once.		21. Signature of Funeral Service Lice	onsee O		F2	anci O Un	gd Agdresse	519 Ins	Funera	1 Hom	ne Inc.	g, MD 20901
			23a: Part1. Enter the disease, or cor	nolications that ca	used he deat							· · · · · · · · · · · · · · · · · · ·	Approximate
			shock, of heart failure. List only Immediate Cause (Final	one cause on ea	ich line.			, <b>.</b>		,			Interval Between Onset and Death
,	Physician /Medical		disease or condition resulting in death)		Cancer								
	Examiner			Due to (	or as a conseq	juence of):							
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a consec	tuence ot):							
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			,							
	and all-tra	xar	that initiated events resulting in death) Last	C. Due to (	or as a conseq	uence ot):				·			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	alE											
87	phys the	dical		d									
9 X	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outo	come of preans	ancv						23d. Date of d	olivos
Box	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bi	nth 2 ☐ Feta ant at time of d	ıl death 3[	Ectopic p					Month	Day Year
Ö	the d	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		J02(II J	7 00101 (3	pacity)			-		
P.0.	thet the dead by the detached	モ	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlyina	cause given in	n Part I.	23e. Di	d tobacco	use contribute	to the cause of death?
Records,	signed b	Completed by					, ,	•		1[	Yes 2	□No 3[7[	Probably 4 TUnknown
Ö	w requir been si should	ete											
ec	e law has t	du								24a. Wi	topsy	24b. Were a	autopsy findings available completion of cause of
=		ဝိ								1 ☐ Yes	rformed? 216 No	death?	s 2 No
/ita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	U					. Place of Dea	th (Check onf	y one)		
Ę	hysi his c	2	1 ☐ Yes 2 ☐ Mo	<del></del>	·	ER/Outpatier			4 Nursing H				ecity) Hospice
2	Mter uners	0	27. Manner of Death 13€Natural 5 ☐ Pending	28a. Date o	f Injury 7, <i>Day Year)</i>	28b. Time of Injury		28c. Injury at Work?		28d. Describ	e how inju	ry occurred	
Sio	eath or: A	catl	2 Accident investigation	ne			М		2 □No				
Division of Vital	irect Irect	Certification:	3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined	4   288. Place	of Injury - At hig, etc. (Specil	ome, farm, str fy)	eet, facto	ry, office		28f. Location City or 7	(Street ar Town, State	nd Number or I e)	Rural Route Number,
Q	ital rel D												
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funerel Director: Alter this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the miner: On the ba and mann	sis of examina	owledge, death ation and/or in	n occurred vestigatio	d at the time, on, in my opinion	date and place, on, death occur	, and due to the red at the tim	ne cause(s e, date and	) and manner a d place, and di	as stated. ue to the cause(s)
	ompl	Me	29b. Signature and title of certifier				29	c. License nu	ımber		29d. Da	te signed (Moi	nth, Day, Year)
			Cypthia m 21,	Mam	,DO.			14005	8032	-		July 28	3, 2006
	10		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type	Print)		000				
			30. Name and address of person who CYNTHAM WILLIAM	15, DO. 1	Montany	nen Has	MICE	GOOL A	Mumerb	×14.110	1 Ro	ckarille.	1020852
	Sta	ite	31. Date filed (Month, Day, Year)	32/Re	egistral Signa	ature		UUUI !	winest	1 1 WULK	M / )"	-ival.ici),	-
1	Regist		JUL 31	2006	egistrale Signa	The sales	3654						

# Please Type or Print in Black Indelible Ink

auren Gail Gry		State of Maryland / Department of Health 1-For State Certificate of Death Registrar	and Mental Hy		g. No.	2089
Physicia Medical Exami	an/	1 Decedent's Name (First, Middle,Last)  Lauren Gail Grymes		2. Date of Death Month August 7, 2		3. Time of Death 1750 hrs
7		4a. Facility Name (if not institution, give street and number)  4b. City, Tow	vn, or Location of Death		4c. County of Death	'a
/ Funeral		Prince Georges Hospital Chever!  5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1		8. Date of Birth	Prince George	hplace (State or
Director		217-86-6119 1_M 2XF 44 Yrs Months	Days Hours Min.	July 28	3, 1962 Foreig	Washington,
any		Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location				10d. Inside City Limits
daryland 28a-f show 1 at once.	ō	Maryland Prince George's Beltsville				1 Yes 2 XNo
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Co		109	g Citizen of What Cour	try'?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene em 27 is marked other than "natural", or items 23a or 28a-f she traumatic eveut, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify C	of Hispanic Origin? ( Sp Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
after dez al", or i	by Fu	1 Yes 2 X No	No specify:		Specify Whit	e
hours		15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Oct	cupation (Give kind of ving life DO NOT use reti		16b. Kind of Business/li	ndustry
036 ithin 72 me r than ledical	ompleted	Graphic Des	igner		Pri	nting
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be Co	17. Father's Name (First, Middle, Last) Richard A. Grymes	18 Mother's Name		aiden Surname) Ltzqerald	
212 ould be d Menti s mark	To B	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (		-		Zıp Code)
MD and 2 sho saith and 2 sit sem 27 is		Richard A. Grymes/ Father 4508 Woodf		Kensing	gton, MD 20	
nore ages la nt of He nt: If it	1	Burial 2 Cremation 3 Removal from State crematory or other place)  Metropolitan Cremat	tory Augi	ust 9,	•	a, Virginia
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important: If item 27 is marked other than "natur injury or other traumatic event, the Nedical Exam	d	4 Donation 5 Other Specify  21. Signature of Funeral Service Licking 22. Name and Ad Francis	dress of Facility ins	2006   Funeral	Home Inc.	WD 00007
Physician	7. 78	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of d				g, MD 20901 Approximate Interval
/Medical	8 19	failure (ist only one cause on each line.  Immediate Cause (Final disease a Head injuries				Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of)  Seguentially list conditions,  b.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ıt <b>e</b> d d ansit		events resulting in death) Last use to (or as a consequence of):				
), be executed sician and urial - transi	ledical	MENDED #23a,27,28a-f, perME, g8	61, 11/30/06	TT		
38760, rtificate be ing physici as the buri	≥	IF FEMALE: 23b Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregna		23d. Date of delivery  Month E	ay Year
Box 687 death certific he attending p	Physician/	4 Pregnant at time of death 5 Other (Specify 9 Unknown	"			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physiciau: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transit	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.		pacco use contribute to	
ords, F w requires s been sign should be	eted			24a Wasa	n 24b. Were au	opsy findings available
Division of Vital Records, tal or Attending Physiciau: The law requires after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed			autops perform 1 ✓ Yes 2	ned? death?	ompletion of cause of s
of Vital Recoling Physiciau: The law After this certificate has uneral director, page 2 sl	Be C		Place of Death (Check	anly one)		
f Vit Physic or this c	ToE	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA	Other Nursir		Residence 6 Other	·
on of ' nding Ph th. r: After t	ion:	1 Natural 5 Pending 12-1 0/6/2006 12-1 1-/5 1	1 Yes 2 vonk?			
Division Spital or Attenchours after death meral Director:	Certification:	2 X Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of	ffice building, etc	28f Location (St	fell down ste treet and Number or Ru ate)4421 Ranch	al Route Number City
Di ospital hours a uneral J		4 Homicide determined (Specify) apartment building	me data and place and	Dertsvill	e, rw	
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29d. Certifying Physician: To the best of my knowledge, death occurred at the tir one)  2 Medical Examiner: On the basis of examination and/or investigation, in my operand manner stated.				
To To Con	Me	29b. Signature and title of certifier 29c. L	icense number		29d Date signed (Mor	nth, Day, Year)
5		Hamfly Wulffull, MA  30 Name a of person who completed cause of death (Item 23a)	J. O.IVI.E.		August 8, 2006	
-	=	Pamela Southall, MD Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD	21201		
S Regis	tate	31 Date filed (Mon A Der Year) 9 2006 32 Régistrar's Signature				

DEWE 17 Rev 172001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 JULY 26 **Physician** JOAN GRIGSBY ENID 6:49 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING
Under 1 Year If Under 24 Hrs MONTGOMERY 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 😿 F Months Hours 220-65-9914 45 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic avent. It is Mindical Equations. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ZIMBABWE 531 RANDOLPH RD APT 323 A 20904 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HAROLD COOPER 2 SYLVIA ADAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALTON R. GRIGSBY/HUSBAND 531 RANDOLPH RD # 323A SILVER SPRING MD 20904 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NORTHERN VIRGINIA CREM. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON 7-30-06 22. Name and Address of Facility ARLINGTON FUNERAL HOME 21. Signature of Funeral Service Licenses nary Holden 3901 N. FAIRFAX DR., ARLINGTON, VA 22203 23a. Part1. Enter the might ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwo Onset and Death Immediate Cause (Final lespirator **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cervical nefastatiz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a sunsequence of). Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Month in the past 12 months?
1 Yes 2 No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No umed? 2 Z No 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only Medi one) 29b. Signature and title of co 29c. License number D0041740 2006 er on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of DR. LIN, JEFFREY Y, 5255 LOUGHBORO RD. NW, WASHINGTON, DC 20016 31. Date filed (Month, Day, Year) 32/Registrar's Signature 31 JUL 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23aPII,25, perME, 9858,8/15/06 Certificate of Death 25696 For A State Registrar 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death MAN **Physician** DEVONNA MAE 25, 2006 12:30A.M. /Medical 4a. Facility Name (If not institution, give street and number)
REEDER'S MEMORIAL HOME 4c. County of Death 4b. City, Town, or Location of Death Examiner **BOONSBORO** WASHINGTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

102 Yre Months Days Hours Min. 8. Date of Birth MAY 12, 1904 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** WEST 234-01-7214 1 M 2 X F 102 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f shov other traumatic svent, the Medical Examinar must be notified at WV **JEFFERSON** RANSON 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 504 PEACH TREE DRIVE 25438 USA itsms 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 □ Never Married 2 □ Married Specify: WHITE 0 1 Tes 2 No Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) INTERWOVEN MILL (GARMENT MANUFACTURER) permit. Pages 1 and 2 should be filed within 7 Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than \* any injury or other traumatic svent, its Mexany pices. ife. PO NOT use retired) INSPECTOR College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be GEORGE CALVIN BOLTZ ANNIE CATHERINE EVERSOLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULINE ADAMS/DAUGHTER 13 PEACH TREE DRIVE, RANSON, WV 25438 20a. Method of Disposition

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of MAY 27 ate 20c. Location - City or Town, State TUSCARORA CEMETERY RFD, MARTINSBURG. W 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821. 21. Signature of Funeral Service Licenses Beaux Charles M. 327 W. KING STREET, MARTINSBURG, WV 25402 Approximate Interval Between Onset and Death MINTH S 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dementia Immediate Cause (Final Physician disease or condition resulting in death) CERT CATION APPROVED BY MEDICAL EXAMINER /Medical Due to (or as a consequence of): Examiner YEARS 4/10/tonin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by the a 1 ☐ Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has t irector, page 2 s 2 No 1 ☐ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 X Yes 2 No 2 ER/Outpatient 3 DOA andir, redeath. for: After th. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Dille signed (Month, Day, Year) 125/06 D0062223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) b

DHMH 17 Rev 1/2001

State Registrar DR. PRAVEEN BOLARUM.

31. Date filed (Month, Day, Year)

)CVONNA

ORIGINAL

32. Registrar's Signature

340 MILL STREET, HAGERSTOWN, MARYLAND 21740

(301) 739-7100

			For State Registrar	State	of Marylar	•	artment of H			giene Reg. No.	006	256	97
			1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Day	Year	3. Time of D	Death
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			123 Mary	Court			LaVa]					egany	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hi		h y, Year)	9. Birth	place (State or ntry)	Foreign
	Director		375-28-6225	X	75	Yrs.			11/12/	1930	Mich		
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City	Limits
	f ehc	៦	MD Alle	egany			LaVale					1 ☐ Yes	21 No
	the 1	Director	10e. Street and Number	,6411 <i>y</i>			10f. Zip Code			10g. Citizen	of What Cou	ntry?	
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Maryland 21215-0036			19a. Informant's Name/Relationsh	ip (Type, Print)			ng Address (Street a			_	wn, State, Zi	o Code)	
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Baltimore,	permit. Pages Department of Important: If I any Injury or a		21. Signature of Funeral Service I	icensee	1		2. Name and Addres						P.A.
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	/Medical Examiner		rossiting in doutry	Due t	o (of as a conse	uence of):	1						
		er	Secuentially list conditions if any, leading to immediate	b. Due t	o (or as a consec	tuence of):							
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			For State Registrar		State of I	Maryland		artment of F rtificate of			giene Reg. No.	2006	25698
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	Examir	er	4a. Facility Name (II MEMORIAI	L HOSPITA		er)		CUMBERLA	r Location of Deat	u)		LEGANY	
	Funeral Director		5. Social Security No. 213-22-333	umber 6. Se	x 7. □ M 2 7 F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1926	9. Birth Mary	nplace (State or Foreign
	and **		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
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Baltimore,	Page ent c nt: If ry or			oosition Cremation 3  Other (Specify		ce ce	metery, crei	esition (Name of matory or other place cmorial Park		-Aug-2006		cation - City or Ma	Town, State aryland
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	750		23a. Part1. Enter the shock, or hear	ne isease, or comp rt failure. List only o	lications that causene cause on each	sed the death. h line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	To the within To the comple	Med	29b. Signature and	title of certifier				29c. Licens	e number		29d. Date	signed (Month	n. Day, Year)
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	Sta Regist		31. Date filed	G 0 7 2001	Reg	istrar's Signat	nre						

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** <u>5:15</u> ₽ <sup>м</sup> 2006 July 31 Grace T. Harps /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11621 Carroll Mill Rd Ellicott City Howard If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 □ M 2X F North Carolina 91 216 48 1102 Nov 16, 1914 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County f show ral', or Itame 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2√2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 11621 Carroll Mill Rd 21042 United States death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2300 If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. be filed within 72 hours after d tal Hygiene. d other then "natural", or Item event, the Modical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) MD State Board of Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Medical Examiners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental William Taylor Rosa Manning 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 or other tra Joyce Harps/Daughter 11621 Carroll Mill Rd Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Holy Redeemer Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 8-3-2006 Belair, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service, Licensee HO1044 | 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician years arteriosce /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 XNo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 【▼ No 24a. Was an page 2 autopsy certificate 2X No e orter 1 ☐ Yes Chron To the Hospital or Attending Physicien: director Be 25. Was case relerred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home St Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 2 1 ☐ Yes 2 ☑ No 3□ DOA this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier K Gallager, No Jaurenco\_ 01786 August 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OKE UN SUITE ANNOUS CANALITE -116 31. Date liled (Month, Day, Year) State AUG 02

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 30 2006 4:15A<sup>M</sup> July Anna June Callihan Hoffman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11329 Eastwood Drive Washington Co. Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Months Days Hours Min. 85 Yrs. 196-34-8751 Nov 24 1920 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ul Hygiene. other then "natural", or itema 23a or 28a-f shovent, the Madical Exeminar must be notified at 1 XYes 2 ☐ No Maryland Washington Hagerstown Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11329 Eastwood Drive 21740 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Š 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Church Activity Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I Leson Callihan Hazel Miller Callihan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is eny injury or other trau 11329 Eastwood Dr. Donna Lee Chaney (daughter) Hagerstown Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐Other (Specify) Greenhill Cemetery Aug 4 06 Waynesboro PA 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Juneral Service License 1331 Eastern Blvd. N. Hagersotwn Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IVer **Physician** Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2/2/No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ၉ this After thi 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation after death.
I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined within 24 hours after dea To the Funeral Directo completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 H0061487 ollin 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03H-10 Colleen M. Sluder, MD 11110 Medical Campus Rd., Hagersotwn, MD 31. Date filed (Month; Day; Year) 32. Registrar's Signature State AUG 0 3 2006 Registrar

			1 - For Stete Registrer	State of M	larylan		artment of F	lealth and N <i>Death</i>		giene 2 ()	06	25701
	Dhuniai		Decedent's Name (First, Middle, I				<del></del>		2. Date of Dea Month		Year	3. Time of Death
	Physici /Medio		Jack Carl HAYS						August	01 2	2006	1559 M
	Examir	er	4a. Facility Name (If not institution, g Washington Coun		•			r Location of Death			County of Death	
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ь	Director		212-14-6157	1 <b>X</b> M 2□ F	86	Yrs.	Months Days	Hours Min.	Nov. 2	9, 1919		aryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
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	or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
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	n 72 hours after death with the Maryland "natural", or liems 23a or 28a-f show selfcal Expenither must be multified at	Funeral	11. Marital Status 1 □ Never Married 2 X Married	12. Was Deceden	?	.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Amend ck, White,	can Indian, etc.
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5-0036	72	eted	15. Decedent's	Education		16a. Deced	dent's Usual Occup	ation during most of work	ina	16b. Kind of B	usiness/In	dustry
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land	should be marked o	ToB	Clarence Edgar	Hays, Sr.					e Floren			
Mary	2 should and Men is marks aumatic	_	19a. Informant's Name/Relationship				-	and Number or Run				
	is 1 and of Health Item 27 other tr	1	Pauline Hays -	wife	205 0		Devonshir sition (Name of	e Road, I				
more,	ii. Pages 1 and 2 should rment of Health and Mer rtent: If Item 27 is marke njury or other traumatic		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3		e C	emetery, cren	natory or other place	ce)	Date	20c. Location -	•	
altin			4 □ Donation 5 □ Other (Special Service Lice		Res		n Cemete	ry  8/4/0				Maryland
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687	ficate phys	edicai	A.	d	11		Pi	eu,	9			THE PUS
Box	death certifii attending p	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnancy			23d. Da	te of delive	өгу
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Division of Vital Records,	quires the n signed ald be de	d by										pably 4 □Unknown
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0	5H-8+1		30. Name and address of person wh	ASHA M	death (Item	23a) (Type, 1	Print) PAC	27. HO	9 GERS	Town	UM	Udy, rear)  OL  YD 2179.
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	Registr	ar	AUG 0 3	2006 %	B. 111	B. 1	rester					

06-05778

Charles Lydell Herbert

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 25702

ando Lyaon v		Registrar	cate of Death		g No	2010
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month	Day Year	3. Time of Death 0227 hrs
edical Exami	ner	Charles Lydell Herbert  4a Facility Name (if not institution, give street and number)	4b. City, Town, or Loca	August 5, 2	4c. County of Death	
		701 Charles Street	LaPlata		Charles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs last bi	,/		n(MM/DD/YYYY) 9 Birt	hplace (State or
Director		220-94-2930 1XM 2F 2	Months Days	Hours Min. 01/25/		ntry) hington, DC
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Maryland 28a-f show any d at once.	ctor	Maryland Saint Marys Me  10e. Street and Number	10f. Zip Code	10	g Citizen of What Cour	ntry?
the Ma a or 21 tified :	Directo	29660 Finch Court	20659		USA	
b, MD 21215-0036 and 2 should halp be filed within 72 hours after death with the Maryland teath and Menbel Hygiene with a state of the Tris marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.		ic Origin? ( Specify Yes or No- exican, Puerto Rican, etc.)	14 Race - Ameri White, etc.	can Indian, Black,
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0036 vithin ene er tha Medic	ldmo	12	Barber		Beaut	ician
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21215-0036 unld be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be		9b. Mailing Address (Street an			Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 3 should be tijed within 72 hours after death Department of Healand and Mental Hygene Important: If item 77 is marked other I han "natural", or iten Injury or other traumatic event, the Medical Examiner must		Alfreda Anita Dickerson Estep/Mother	29660 Finch Court		lle, Maryland	
Baltimore, MD bernit Pages I and 2 sho Department of Health and Important: If item 27 is nijury or other traumat			e of Disposition (Name of cemete atory or other place)	ery, Date	20c. Location - City or	Town, State
imo Page ment c tant: or oth		4 Donation 5 Other Specify Sacre	d Heart Cemetery	August10,2006	Bushwood, MI	)
Balt Depart Impor Injury		21.8 gnature of Funeral Service Licensee	22. Name and Address of Mattingley-G	Facility ardiner Funeral Ho , Leonardtown, MD	ome, P.A.	
Physician	- '	23a. Part I. Enter the disease, or complications that caused the reath. Do	not enter the mode of dying, suc	, Leonardtown, MD h as cardiac or respiratory arre	st, shock, or heart	Approximate Interval
/Medical Examiner	SI 1	failure. List only one cause on each line.  Immediate Cause (Final disease a. Cocaine intoxicati	.on			Between Onset and Death
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ivisior or Attent after death Director:	catio	2 Accident Investigation 28e Place of Injury - 4t home	ink	<sup>2</sup> X No unk	Street and Number or Ru	ral Route Number City
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To the within To the To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/o and manner stated.				
. ,,,,	Σ	29b Signature and title of certifier	29c License ni		29d. Date signed (Mo	ntn, Day,Year)
		30. Name and address of person who completed cause of death (Item 23a	Market Property Control of the Contr	<u>-</u> .	, luguot 0, 2000	
			1 Penn Street, Baltimore	e, MD 21201		
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Regis	stra					

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 7:20 PM Anna Marian Hahn August 6 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day Year)
Dec. 15, 1918 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🖫 F 220-26-2392 87 Maryland Director Usual Residence of Decedent the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow the Medical Examiner must be notified at Frederick Maryland Frederick 1X Yes 2 No Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? With or itema 23a or 750 Carroll Parkway, Apt. 1A 21701 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if them 27 is marked oth any lighry or other traumatic event opne. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Garfield Phebus Bessie Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia A. Shafer, daughter 6913 Greenvale Court, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 24 Cremation 3 Removal from State Smithsburg Crematory Aug. 11, 2006 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE THRIVE **Physician** TO /Medical Due to (or as a consequence of): Examiner COLON CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the deeth certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physicien Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy igned by the atter in the past 12 months? Month Day Year 4 Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 20 No 1 Yes within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D047951 -8 - 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOUSE FREDERICK, Mn 814 TOU SIBTERKALMI 31. Date filed (Month, 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 5, 2006 Year **Physician** ARBUTUS E. HORNER 12:40 PA /Medical 4b. City, Town, or Location of Death WILLIAMSPORT 4a. Facility Name (If not institution, give street and number)
HOMEWOOD AT WILLIAMSPORT Examiner 4c. County of Death WASHINGTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/19/19/16 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 VF WEST VIRGINIA 89 Yrs. 214-28-7396 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "neturel", or items 23a or 28e-f ehow the Madical Exeminer must be nutified at 1 Yes 2 No FALLING WATERS BERKELEY Director W۷ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25419 USA 2417 BROAD LANE filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: WHITE Specify: ģ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othnerly injury or other treumatic event, 90058. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GRANT U. KNIPPLE CORA B. ALBRIGHT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13111 GOLDEN OAK DRIVE, LAUREL, MD 20708 HENRY HOUCK/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 △ Surial 2 □ Cremation 3 □ Removal from State AUGUST<sup>Date</sup> 20c. Location - City or Town, State MARTINSBURG, WV ROSEDALE CEMETERY 11,2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facili BROWN FUNERAL HOME MARTINSBORG, WV 327402 hacesm Biron 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Duermania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the attending physicien and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ens10autopsy rmed? 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death | Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💓 No ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Natural 5 Pending death. 1 □Yes 2 □No 2 Accident investigation within 24 hours after death To the Funerel Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier CSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 08-06-9006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Hagerstown MD 21742 13424 2250 MD Emnsylvania 31. Date filed (Month, Day 32 Segistrar's Signature State Registrar TORAN S

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Robert Tudor Holdren III 06 0045 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death PENNISHA RÉGIONAL MEDICOL CENTER SALISBUKA Hicanica If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-2-1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) Months Days Hours 100 M 2□F 85 New York 226-03-8573 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No Pocomoke City Somerset 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21851 7510 Pocomoke River Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 TYes 2 No WW II If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Inge Robert Tudor Holdren Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7510 Pocomoke River Road, Pocomoke City, MD 21851 Nancy Holdren / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Salisbury Crematory 8/01/2006 Salisbury, MD 21804 4 ☐ Donation — 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 103 Linden Ave. Holloway Funeral Home, P.A. Pocomoke City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Aspisation Due to (or as a consequence of): VA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕽 № 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No

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Division of Vital Records, P.O. Box 68760,

by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 atient 2 TV No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			30. Name and address of person	who completed cause	of death (Item	123a) (Type.	Print)	6	ANNI	mars	m	21401		
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	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ce of):										
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	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequent	Ce OI).										
	al-trai	xar	that initiated events resulting in death) Last	C. Due to (or as	a consequen	ce of):								+		
760,	ite be executed lysician and ne burial-transit	cai	(	d			,, <u>.</u>									
89	tificat ng ph) as th	fedi		77												
Вох	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome 1 ☐ Live birth			∃Ectopic pre	gnancy				2	23d. Date of o			Year
о П	Attending Physician: The law requires that the death certificat r death.  Gotor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	n 5[	Other (spe	ecity)			***		WOTE	,	Jay	1001
	that ti	y Ph	Part II. Other significant conditions	contributing to death b	ut not resultin	ng in the u	nderlying ca	iuse given	in Part I.		23e. Did to	bacco u	se contribute	to the	e cause of	death?
rds	quires tha n signed uld be del	Q P	Hypertension								1 🗆 Y	es 20	□No 3□	Proba	ibly 4 🏋	Unknown
00	aw requir s been si 2 should I	piet	Type II Diabe	tes Mellit	us						24a. Was		24b. Were	autop	sy findings	available
æ	The I	Completed										med? 2 No	death	?	npletion of ∈ 2□ No	cause of
<u>ita</u>	ian: rtifica ctor. p	BeC	25. Was case referred to medical examiner?					2	26. Place	of Death	(Check only o					
<u>5</u>	hysic his ce I dire	To	1 ☐ Yes 2 No	Hospital: 1  Inpatie	ent 2 KER	/Outpatier	nt 3 DO	A Other:	4 🗆 Nurs	sing Hor	ne 5 🗆 Resid	lence 6	Other (S	oecify)	)	
n C	ing P	.i.o	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28	b. Time o Intury		Bc. Injury a Work?			8d. Describe h	ow injur	y occurred			
Sic	ttend death stor: /	icat	2 Accident Investigation 3 Suicide 6 Could not		une. At home	form of	M .		s 2 N		8f. Location (S	treet an	d Number or	Dural	Pouta Nur	phor
Division of Vital Records,	s after s after s after s od in by	Certification;	4 Homicide determine		c. (Specify)	, iaiii, su	eet, ractory,	, onice			City or Tow			riurai	710010 140	11067,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	Physician: To the best aminer: On the basis o and manner st	f examination	dge, deat and/or in	h occurred a vestigation,	at the time, in my opin	, date and nion, death	d place, a h occurre	nd due to the old at the time, o	ause(s) date and	and manner place, and c	as sta ue to	ited. the cause(	s)
	To th within To th compl	Me	29b. Signature and title of certifier	1111			29c.	License r	number			29d. Dat	e signed (Mo	njh, D	Day, Year)	
)			> Ulllan	1+ U/Z	nen		- 0	リ	39	16		07	131	10	2006	
	311		30. Name and address of person who					- C+	т	1	M_	1 1	0070	7		
63	Sta	te	William A. Warre 31. Date filed (Month, Day, Year)					e st	., La	urel	., Mary	Land	2070	)/		
14	Registi		AUG 01	2006	a di	G	will									

			For State Registrar	State of Mary			of Health a of Death	ind Mental Hy	giene Reg. No.2 0 0 6	25708
			1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Day Year	3. Time of Death
	Physici /Medic		Laura Ella	Julious				Augus		
	Examin		4a. Facility Name (If not institution, given				wn, or Location o		4c. County of Dea	
			6805 Sisalbed				tol He			Georges
	Funeral			Sex 7. Age (li 1 ☐ M 2 🛱 F	n yrs. last birthday) Q 7 Yrs.	If Under 1 Y Months D	ear If Under 2 ays Hours	Min. 8. Date of Bir	y, Year) C	thplace (State or Foreign ountry)
	Director		270-26-0631   Usual Residence of Decedent		87 Yrs.	L		July	11,1313	West VA
	yland		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mar.	ţċ	Md. Po	G	Capito.	l Heig	ghts			1X Yes 2 □ No
	or 28	)ire	10e. Street and Number			10f. Zip Co			10g. Citizen of What C	•
	9th w	Funeral Director	6805 Sisalbed	T			20743		United S	
	er de	une	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent If Yes, specify	t of Hispanic Orig Cuban, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1⊡Yes 2K	No Specify:		Specify:	1-
21215-0036	within 72 hours after deeth with the Maryland ene. then "neturel", or Iteme 23e or 28e-f ehow the Medical Exempler must be notified at	ed	15. Decedent's E	ducation	16a. Dece	dent's Usual O	ccupation		16b. Kind of Business	.ack Vindustry
215	hin 7,	ple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work d DO NOT use r	done during most etired)			
S	filed withi Hygiene. other then	Completed	12		I.	lousek			Cleveland	Clinic
pu	d oth	Be	17. Father's Name (First, Middle, Las.				Driver of	r's Name (First, Middle	, Maiden Sumame)	
Maryland	s 1 end 2 should be filed within 72 hours after deeth with the Marylan I Heath and Mental Hyglene 1 Heath and Mental Hyglene 1 Heath and Mental Hyglene 2 how item 27 is marked other then "neturel", or items 23a or 28a-1 ehow other traumatic event, I'm Medical Examiner must be notified at	은	Bennie Harri		10h Maili	a Address /C	Cor		er, City or Town, State,	Zin Code)
Mai	d 2 sho th and 7 Is mu traum		19a. Informant's Name/Relationship		noue i n	6805	Sisalb	ed Drive		Zip Code)
	permit. Peges 1 end 2 Department of Health Importent: If item 27 i any injury or other tra ance.		William E. Edw 20a. Method of Disposition	alus si./C	20b. Place of Dispo	Capit sition (Name)	of Hei	ed Drive ghts, Md.	20743 20c. Location - City or	Town, State
JOI L	Peges nent of int: If its		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	21 101110 Val 110111 Otato	cemetery, crer	_		8/10/06	Suitland	ьм І
Baltimore,	artme ortan		21. Signature of Funeral Service Lice						Edwards	
ä	permit. Departr Importe any inje		Janice)	Exuraida				_		l,Md.20746
			23a. Par(1. Enter the disease, or con shock, or heart failure. List only	aplications that caused the	death. Do not ent	er the mode o	f dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Failure					Onset and Death
	/Medical		resulting in death)	Due to (or as a c		,				
	Examiner		Sequentially list conditions,	ы Periphe	eral Vas	cular	Diseas	se		
,	p <sub>e</sub> =	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	,					
1	and and Il-tran	хап	that initiated events resulting in death) Last	c. Hyperte						
8760,	be e.	ical Examiner			Y Arter	v Dis	ease			
687	certificate be executed nding physician and use as the burial-transit			d. OOLOHAI	J, MI CCI	DIO	case			
Вох	Se ig	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Testonio arass	2000		23d. Date of de	livery
	equires thet the death sen signed by the atter rould be detached for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 🎛No	4 Pregnant at tim		∃Ectopic pregr ∃ Other (s <i>peci</i> i			Month	Day Year
P.0	et the	hy	9 Unknown							
	res th iigned be de		Part II. Other significant conditions		ot resulting in the u	nderlying caus	se given in Part I.		obacco use contribute t	
orc		eted	<u>Diabetes Mell</u>					-	195 2 NO 3 F	robably 4 XJnknown
Division of Vital Records,	e law hes b	Completed by	_Hyperlipidemi	a				24a. Was		utopsy findings available completion of cause of
a E	Physician: The lav this certificete hes al director, page 2					_		1 ☐ Yes	2X No 1 ☐ Ye	s 2⊠ No
× ×	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpatier	4 2 DO4		of Death (Check only o	one) dence 6 □Other (Spe	
ō		7: To	27. Manner of Death	28a. Date of Injury (Month, Day Yo			Injury at Work?		how injury occurred	ecity)
ion	nding Ph ath. r; After th e funeral	ation	1 □Natural 5 □ Pending 2 □ Accident investigation		ear) Injury	М	Work? 1 ☐ Yes 2 ☐ I	No		
vis	Attendi ar death. ector; A by the fu	tific	3 ☐ Suicide 6 ☐ Could not determined			reet, factory, or	ffice	28f. Location ( City or To	Street and Number or R	lural Route Number.
Ö	rs afte	Certification:		Saliding, otos (						
	Hospital 94 hours a Funeral tely filled	Cal	(Check only 2 Medical Exa	hysician: To the best of n miner: On the basis of ex	ny knowledge, deat amination and/or in	h occurred at t vestigation, in	he time, date and my opinion, deat	d place, and due to the	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	one) 29b. Signature and title of certifier	and manner stated	l.		icense number		29d. Date signed (Mon	
	7 × 10 0		200. Signature and title of certifier	. ^					-	
	. \		Agreement accepts the page of accepts of acc	completed cause of days	h /Itom 22a) /Tue-		48158		August 8,	2006
	H		30. Name and address of person who Dr. Sisom Osi				l pa a	nite #FO	0.011 1111	11 11 2 22 - 1
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		ru.,S	urre #50(	, uxon Hi	ll,Md.20745
	Regist		AUG 15	2006 Margan	, 13 6	beste				

		1	State of N		artment of Health and Martificate of Death	Mental Hygier Reg. 1	ZUUb	25709
	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last)  GENEVIEVE	KRUF	PINSKI		Pay Year OG	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and number Carroll Hospital Center 5. Social Security Number 6. Sex 7. /	r) Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Westminster  If Under 1 Year   If Under 24 Hrs.		4c. County of Death  Carrol  9 Birthol	
	Funeral Director		215-18-8816  Usual Residence of Decedent	83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes July 28	1923	ace (State or Foreign ry)  MD
	Maryland -f show lied at	. 1	10a. State 10b. County  MD Carroll	10c. City, Town or Lo	minster		10	0d. Inside City Limits 1 ☐ Yes 2 ☐ <b>X</b> Io
	h tha	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	ry?
	23a c	rai	1423 Lloyd Drive		21158		USA	
5-0036	ges 1 and 2 should be filed within 72 hours aftar death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svant, it is Madical Exam nor must be notified at	by Fur	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Volvorced  12. Was Deceder Armed Force 1 Yes, Give Year or Dates	<b>3</b> %0	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, 6 Specify: Whi	etc.
5-0	72 ho "natur dical	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring 16b	. Kind of Business/Ind	ustry
2121	filed within Hygiene. Ithar than "	Completed	Elementary/Secondary (0-12) College (1-4c	r 5+)	Seamstress		Haaf Tailo	oring
DC 2	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic svant, Itte Ma	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Maid	fen Sumame)	<b>J</b>
ylaı	should b and Menta marked umatic s	10	John Chludzinski			nna Bornit		0.41
Maryland	d 2 sh th and th srr 17 Is rr traur		19a. Informant's Name/Relationship (Type, Print)  Joann Winkelman/Daughter		ng Address (Street and Number or Rui 3 Lloyd Drive We	stminster,		_
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.	W. C. C.	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from Sta  4 □ Donation 5 □ Other (Specify)	le l	osition (Name of matory or other place) ranch Cemetery 8/		Location - City or To Vestminster	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens		Name and Address of Facility ritts Funeral Hom 12 Washington Road			21157
8760,	/Medical Examiner and the private and the private transit.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):  as a consequence of):  as a consequence of):  as a consequence of):	rebono Valular Lenotic Ca	Heridu Who was	ular 1	Onsetany Death  10 ylar
O. Box 6	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Completed by Physician/Med		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
Ω.	quires that t in signed by uld be deta	ed by Ph	Part II. Other significant conditions contributing to death	n but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death? ably 4 Unknown
of Vital Records,		Complet				24a. Was an autopsy performed 1 Yes 2	prior to cor death?	osy findings available inpletion of cause of
Vita	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:	2758/0-4-4	Other	th (Check only one)	e 6 □Other (Specify	1
o	g Phys er this eral di	n: To	1 Ves 2 No 1 Inp.  27. Manner of Death 28a. Date of I (Month, (Month,		THE SELECT A TRUISING TO	28d. Describe how in		)
Division	To the Hospital or Attending within 24 hours after death.  To the Funaral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farm, st etc. (Specify)	M 1 Yes 2 No	28f. Location (Street City or Town, St	t and Number or Rura tate)	Route Number,
	a Hospita 24 hours a Funaral letely filled	ledical C		of examination and/or in	th occurred at the time, date and place, vestigation, in my opinion, death occur			
	To th To th compl	Me	29b. Signature and title of certifier		29c. License number \$ 38915		Date signed (Month, 1	
			- + + + + + + + + + + + + + + + + + + +	t de eth (lane 02a) (Tema			<u>-</u>	
	10		KHALL FREIGI	of death (Item 23a) (Type,		ue med	1/30/06.	2/157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Katherine Month Year Physician 2:16 PM Kemp 70 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner oF. GIF hore MD
If Under 1 Year | If Under 24 Hrs. Baltinare Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 M 200 F 214-36-5385 Yrs Director 125/1933 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Director MD CAROLINE DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25272 PEALIQUOR RD. 21629 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 le marked ott jury or other traumatic even ARTHUR ORVILLE NASH, SR. KATHERINE MARY REESE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HERMAN KEMP, JR. / SPOUSE 25272 PEALIQUOR RD., DENTON, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 8/3/2006 EASTON, MARYLAND 21. Sign turn of Puneral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 Part1. Enter the disease, or complications that cashock, or heart failure. List only one cause on ag Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Respirates /Medical Due to (or as a consequence of): Examiner 1. Hiple Blood Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit An Dreat and Due to (or as a consequence of): Box 68760, igned by the attending physician be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 Tyes 2 No Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. May er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Marc

31. Date filed (Month, Day, Year)

MD.

2 2006

22

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

Gibbes

D1971

30/0

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JULY 11:40 A M 30, 2006 KLIMEK ELIZABETH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 8. Date of Birth (Month, Day, Year)
APRIL 21,1939 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🂢 F WASH. D.C. Director 578-54-4461 Usual Residence of Decedent Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland nent of Heatth and Mental Hygiene. and them 27 ie marked other then "neturel", or items 23a or 28s-1 show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State other traumatic event, the Madical Examiner must be notified at TY□Yes 2□No Completed by Funeral Director PRINCE GEORGES BRENTWOOD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 20722 U.S.A. 3403 TILDEN ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married ☐Yes 27 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: 3X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 Elementary/Secondary (0-12) STATE OF MARYLAND FISICAL CLERK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ENGLISH PAULINE CURTIS J. HENRY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BRENTWOOD, MD. 20722 V. KLIMEK/SON 3403 TILDEN ST., **JAMES** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Its eny injury or of once. 1 Burial 2 Cremation 3 Removal from State CHAMBERS CREMATORY | 7-31-2006 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD. 21. Signature of Funeral Service, Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by should be 4 Winknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 NO certificete 1 Yes 20 To the Hospital or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 patient 2 ER/Outpatient 3□ DOA Certification: To this After this funeral of Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Marrier of Death 28d. Describe how injury occurred Mura 1 🗌 Yes 2 Accident 2 No hours after death. investigation within 24 hours after death To the Funeral Director: completely tilled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai (Check only one) and manner stated. 29c License number 29d. Date signed (Month, Day) Year, 29b. Signature and title of certifie TAKOMA PAR npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person che State AUG 0 2008 Registrar

			1 - For State Registrar	State o	of Marylar			nt of H te of L		and M	ental Hy	giene	ZUL	15	25	712
	Bloodel		1. Decedent's Name (First, Middle, Las	it)							2. Date of De Month	eath Da	v Y	'ear	3. Time o	f Death
	Physicia /Medic		Isobel Hauser Katz								July 2		006		1:30	РМ
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	Funeral Director			M 2 <b>X</b> □F	r. Age (at yrs.	94 Yrs.	Months		Hours	Min.	8. Date of Bi (Month, Di Nov 3	ay, Year)	911 T	Coun	try)	or r oraigir
			Usual Residence of Decedent								110 7 3	, 1				
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and S	hair H	Be	17. Father's Name (First, Middle, Last) Abraham Morris Hau							Dia		s, maider	(Surname)			
2	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship			19b. Mailie	na Addre	ss (Street a			Route Numb	er. City o	or Town, St	ate. Zip	Code) 20	910
<u>≅</u>	lith ar 27 is r trau		JoAnn Morris/daugh	-		2223	Wasl	ningt	on Av	renue	Apt.	204	Silve	r Sp	ring,	MD
<u>6</u>	s 1 ar		20a. Method of Disposition		20b.	Place of Dispo cemetery, crei	osition (N	ame of other place	e)	D	ate	20c. L	ocation - Ci	ty or To	wn, State	
Ë	Page net c int: If iry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from v)	State	esapeal				08/0	1/06	Bel	tsvil	le,	MD	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Mucical Examinar must be notified at page.		21. Signature of Funeral Service Liver	elt	M012	51 G	bing ever	MAME Ly L.	e CFell Heck	ation	Serv	ice :	P.O. arksv	Box ille	784 • MD	21029
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.	th. Do not ent	ter the ma	de of dying	g, such as	cardiac oi	r respiratory a	arrest,			Approxima Interval Be Onset and	tween Death
į.	/Medical		disease or condition resulting in death)	a	lasia (or as a consec	quence of):								+	years	
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P.O.	thet the de sed by the e detached t	hys	9 🗆 Unknown					_			+	_ 1		- 57		
	8 50	δ	Part II. Other significant conditions of				inderlying	cause give	en in Part I.						e cause of o	
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Division	of or Attend efter death Director: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	209. Plac	e of Injury - At h ling, etc. (Speci	iome, farm, sti fy)	reet, facto	ry, office		2	8f. Location City or To			or Rura	Route Nun	nber,
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)ai	2		30. Name and address of person who		se of death (Ite			Von	eine+	on 1	MD 208	95				
		ı to	Neelam Shahi, M.D  31. Date filed (Month, Day, Year)		U COnne		Ave	• Kell	STIIRL	.0119	Z00	<i></i>				
	Sta Registi		AUG 0 1				Lack									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Date of Death
 Month

JULY

Day

2006

4c. County of Death

28,

Year

3. Time of Death

4:30 A.

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** Liza Kroupnik /Medical 4a. Facility Name (If not institution, give street and number) Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene William Charles Logan 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ July 28, 2006 1726 hrs Medical Examiner William C. Logan c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cecil 207 Meadow Creek Lane Apartment B Elkton If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number Age (In yrs. last birthday **Funeral** Months Days Hours Director Country) Delaware 1X M 2 Yrs March 27,1943 63 222-26-1087 Usual Residence of Decedent 10d Inside City Limits any. 10a State 10c. City. Town or Location Yes 2 X No or 28a-f show Maryland Ceci1 E1kton it Pages I and 2 should be filed within 72 hours after death with the Maryland trumen of Health and Mental Hygiene.

Totalt: If item 27 is marked other than "natural", or items 23a or 28a-f sht oy or other traumatic event, the Medical Examiner must be nooffied at once rector 10a. Citizen of What Country' 10e. Street and Number 10f. Zip Code ō 207 Meadow Creek Lane, Apt. ted States 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1X Yes No If Yes, Give Year 3 X Widowed 1 Yes 2 No specify: Specify: White Divorced 2 or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Truck Driver Federal Express 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Francis Logan Erma Wilkenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kelly Logan/Daughter Jefferson Avenue, New Castle, Delaware 19720 position (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 31, Burial 2 X Cremation 3 Removal from State portant: ary or oth 2006 Newark, Delaware Donation 5 Other Specify Mayerdale Crematory 22. Name and Address of Facility Crouch Funeral Home 21. Slana ure of Euneral Service L 127 South Main Street North East, Maryland 21901 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Contact Gunshot Wound to Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED burial -Box 68760 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy phy the 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Month attending or use as t Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) or Yes 2 No 9 Unknown been signed by the should be detached f Division of Vital Records, P.O. 124 hours allow requires that the 24 hours after death and the funeral Director: After this certificate has been signed by the etely filled in by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed death? 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: \$cene 1 V Yes 2 2 No 28a. Date of Injury (Month, Day, Year FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Subject shot self Certification: 1 Natural FOUND: 1 Yes 2 V No 5 Pending Jul 28, 2006 1715 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be 207 Meadow Creek Lane Apartment B, Elkton, M (Specify) Multi-Family Apt. To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of O.C.M.E. July 29, 2006 30. Name and address of person who completed cause of death (Item 23a) 5+IVA Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD.

State Registra

Registrar's Signature

/Medical	Bonnie	irst, Middle, Lasi Jean		Ludwig					2. Date of D	Day	2006	3. Time of Death
	4a. Facility Name (If not					4b. City.	Town, or	Location of Death	July	4c. Cou	nty of Death	11,00
Examiner	Doctors Co	. 3					anha			l l	nce Geo	orge's
ineral rector	5_Social Security Numb 534-34-313 537-37-3937	6 50		7. Age (In yrs. 70	last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of B	<sup>irth</sup> Yea 1935		lace (State or Foreign
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	19a. Informant's Name/ Melody Jear			ichtor				nd Number or Ru d Lane,				
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				State of Marylan	d / Depa		ealth and N	Mental Hyg	_	06	25716
			Decedent's Name (First, Middle, Last)					2. Date of Deat		3	. Time of Death
	Physicia /Medic		WILLIAM		.OWE			JULY		06	1:45 P M
À	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or		l			
			CITIZENS CARE AND I			FREDER		1 (0:1)	FREDE		(2)
	Funeral Director		291-12-/384	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 10	Year) 1921	9. Birthplace Country) Mary	e (State or Foreign 7land
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10c Cib	y, Town or Lo	ncation				10d	Inside City Limits
	aryla ehon	_	Md. Freder		rederi						1 ☐ Yes 2 X No
	Ba-f	ct									
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow he Madical Examilier must be colified at	by Funeral Director	10e. Street and Number 5860 Genesis Lane	#421		10f. Zip Code	21703	1	0g. Citizen of Wh United		
	ath v	<u>a</u>			2 112			V			
	ep	ıne	Tr. Warter States	2. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		<ul> <li>American</li> <li>White, etc.</li> </ul>	
9	afte or if	Ē	1 Never Married 2 Married	1 X Yes 2 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	Whi	Lte
g	ural',	Q p	3 Widowed 4 Divorced	Year or Dates: WW.L							
5	72 h natu	ete	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of	furing most of wor	king	16b. Kind of Bus	iness/Indust	.ry
2	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired, cavator	)		Excava	ation	
2	filed w Hygier other th	Completed	7	0	E-2	Cavacor					
Maryland 21215-0036	d la b	To Be (	17. Father's Name (First, Middle, Last)  John W. Lowe	9			18. Mother's Nam Mildre	ne (First, Middle, M ed Ada		)	
2	should I nd Meni marke	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (Street a	and Number or Ru	rai Route Number	, City or Town, S	tate, Zip Co	de)
S	and 2 ealth a n 27 is		Helen E. Lowe /	Wife	5860	Genesis	Lane #4	121, Fre	ederick,	Md.	21703
a)	1 ar Hea Hem Sthe		20a. Method ol Disposition			osition (Name of matory or other place		Date	20c. Location - C	ity or Town	State
٥	Pages nent of I ant: If Its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State			- 10	1/06	Alexandı	ria. V	la .
₽	thent rtent		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee			itan Crem					
Baltimore,	permit. Pages 1 and 2 3 Department of Health ar Importent: If Itam 27 is any Injury or other trau		21. Signature of Funeral Service Licensee	Bert	,	2. Name and Addres Muriel H.					
	HD340		money 14	. Burne	7/			Laytonsv			0882
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	n. Do not en	ter the mode of dying	g, such as cardiad	or respiratory arre	est,	Int	pproximate terval Between nset and Death
	Physician		Immediate Cause (Final disease or condition	A Ch	to f	ZINAL	+11/	1168		1	11/14/15
A. St.	/Medical		resulting in death)	Due to (or as a conseq	uence of):	- 1					1/1
н	Examiner		Sequentially list conditions b.	110	PAS	15				2	WPYRL
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence ol):						
	cuted	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last								
o,	sicien and burial-transit	Ä	resulting in death) Last	Due to (or as a conseq	uence ol):						
760,	The law requires that the death certificate be executed ste has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	cai	d.								
68	ires that the death certificate signed by the ettending phys de detached for use as the	Physician/Medi								1	
Вох	ndin use	Z	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna 1 Live birth 2 Feta		☐Ectopic pregnancy			23d. Date	ol delivery	
_	death d for	lcia	in the past 12 months?	4☐Pregnant at time of d		Other (specify)			Mont	h Da	y Year
P.O.	the dy the	ys	9 □Unknown	9□ Unknown							
	that		Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	underlying cause give	en in Part I.	23e. Did tot	pacco use contrib	oute to the c	ause of death?
ds	uires Id be	d by	Alybimy	DIMY9 11	M			1 🗆 Ye	es 2□No 3	Probabl	y 4 Unknown
ò	w requir been si should	Completed	N.S. L. Yu M	1/1/				24a. Was a	n 24h W	ere autonev	findings available
š	e lav	n p	-171 WD 4/23 /21	7///195	//	// /		autops	by pri	ior to complicath?	findings available etion of cause of
=	: Th	S	154 MIAH Pr	vitatie /	14/146	Trong		1 ☐ Yes	2000 1 [	Yes 2	] No
/ita	cian ertifi ector	Be	25. Was case relerred to medical / examiner?	7/10/10/10/1	//	1 / 200		ith (Check only on	e)		
<u></u>	hyei his c	2	TU TES ANO		ER/Outpatie		4 Nursing H	ome 5 Reside			
o L	ng P fter t inera		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	y at k?	28d. Describe ho	ow injury occurre	d	
0	ath.	ati	2 Accident investigation			M 1	Yes 2 □ No				
Division of Vital Records,	Pr der de by ti	ti di	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, larm, st	reet, lactory, office		281. Location (St City or Town	treet and Number n, State)	r or Rural R	oute Number,
Ö	s aft	Certification:									
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only 2 Medical Examin	cian: To the best of my known: On the basis of examina							
	the the mplet	Med	one) 29b. Signature and title of certifier	and mariner stated.		29c. License	e number		9d. Date signed	(Month Day	v. Yearl
	5 <u>1 × 5</u> 5		A A	/ //	, -	111	1120	-	7/2	121	
	141		MUM	Muni	117	)	6 KD FO		1/51	105	0
<	J''			heleted cause of death (Iter			n Gw m	ער דמים חים ס	MTA 4	1701	
-				III, M.D.		WEST NINT	п эт., г.	VEDEKTOK.	, мр. 2	T/01	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AIIG 0 1 20	32. Pegistrar's Signa	K A	parte					

			epartment of Health and M Certificate of Death	lental Hygier Reg. N	-/ U U D	25717
Physi	cian	Decedent's Name (First, Middle, Last)     Adriana Jean Le	ee		Day Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give street and number)  Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederic		4c. County of Death	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  0 3 2	8. Date of Birth (Month, Day, Yea		ce (State or Foreign r) aryland
aryland show	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  MD Calvert	or Location  North Beach		100	1. Inside City Limits 1 XYes 2 No
with the M a or 28a-f Le notifi	Director	10e. Street and Number	10f. Zip Code 20714	10g. (	Citizen of What Country U.S.A.	13
ING 21213-UU30 be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. d other than "natural", or items 23a or 28a-f show event. Its Medical Examinat must be rectified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  1	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🕅 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc Specify: White	
C 21215-UU36 filed within 72 hours af Hygiene. ther than "natural; or ant, Its Medical Exami	Completed b		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Never Worked	ing 16b.	Kind of Business/Indu	stry
iryland 212 should be filed with ad Menta! Hygiene marked other tha matic event, Item	Be			e (First, Middle, Maid		
Ma d 2 s th ar th ar trau	To	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Run 8823 9th Street North Beach, N		y or Town, State, Zip C	ode)
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra		1 Buriai 2 Cremation 3 Semoval from State	y, crematory or other place)	Date 20c.	Location - City or Tow Alexandria	
bermit. Pag Department Important:	OUC8.	21. Signature of Funeral Service Licensee  **Dlacky** Q: Servell  23a. Part 1. Enter the disease, or complications that caused the death. Do not be a server of the death.	22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Ro			'8 Approximate
(8760) cate be executed Examine physician and the burial-transit	al	Due to (or as a consequence	on: PCIGOHYDRAMNIC on: Rupture of	s Hembra		nterval Between Onset and Death
BOX 6 eath certifi attending for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)			y Day Year 30 2006
dS, P. uires that the signed by Id be detact			n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
of Vital Records, P.O.  Physician: The law requires that the deprise contilicate has been signed by the ral director, page 2 should be detached	Completed			24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
Vision of Vital Rec Attending Physician: The lav redeath. ector: After this certificate has by the funeral director, page 2	atlon: To Be	examiner? 1 ☐ Yes 2 XNo Hospital: 1 ☑ Inpatient 2 ☐ ER/OL	Other	28d. Describe how in		
Division tal or Attending s after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
Division of To the Hospital or Attending Phi wit in 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 Medical Examiner: On the basis of examination are one)	nd/or investigation, in my opinion, death occur	rred at the time, date	and place, and due to	the cause(s)
To To To Confi	2	Inby Chyr, M.D	D 002970	02	8.7.20	06
	CANA	30. Nam and address of person who completed cause of death (Item 23a)    C U B	100 Hospifal	1 Rd. 1	Prince F	rederia
Reg	State istrar	AUG 1 0 2006 > Beauco	It sparks		IID	20018

			1 - For State Registrar	State of Marylan		artment of F		d Mental Hy	/giene Reg. No	/ 1111-	25	718
	Discontinui		1. Decedent's Name (First, Middle, Las					2. Date of D Month	eath Da	y Y <i>e</i> ar	3. Time of	Death
	Physicia /Medic		Karen Beatrice L	agnese				July		2006	8:45	рм
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of C	eath	4c.	. County of Deat	h	
			Montgomery Hospi			Rockvil					gomery	
1	Funeral		5. Social Security Number 6. Se	_ X		If Under 1 Year Months Days		Min. 8. Date of B (Month, D June 2	irth Jay, Year)	9. Birt	hplace (State of untry)	
	Director		100-30-3070	□M 2□F 69	Yrs.			June 2	o, 1	937 Peni	isýlvan:	la
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside Cit	ty Limits
	Aaryl 1 eho	ō	Maryland Montgo	merv	Silver	r Spring					1 🗌 Yes	2 No
	28a-	Directo	10e. Street and Number		511.01	10f. Zip Code			10g. Cit	izen of What Co	untry?	
	filed within 72 hours after death with the Maryland Hydione. ther than "natural", or items 23s or 28s-f show int. the Madical Examinar must be notified at	0	1617 Chester Mi	11 Road		20906				USA	ŕ	
	leath	Funeral	11, Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of I	lispanic Origin	? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ame		
	r iter	교	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				ruerto Rican, etc.)		Black, Whit		
<u> </u>	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify.Whit	-e	
215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occup	oation during most of	working	16b. K	ind of Business/	Industry	
7	ithin Ba	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	d)					
2	ygier ygier f.	S			Keć	gistrar		A1. (5: A A1.1)		lic Scho	or syst	cem
ב	itai H id oth	Be	17. Father's Name (First, Middle, Last)  Joseph Lawrence	Friedrich				Nam <i>e (First, Middl</i> rice Nich		Sumame)		
<u>Ş</u>	should be and Mental marked o umatic eve	ပ										
-	and raum		19a. Informant's Name/Relationship (7  John E. Lagnes					or Rural Route Num Road, Sil				06
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filed within 172 hours after 6 seath with the Marylan Department of Health and Mental Hydiene.  any injury or other traumatic event, the Marchael Examinar must be notified at once.		20a. Method of Disposition	20h F	3-2-0/2-	osition (Name of	T	Date		ocation - City or		
altimore,	Pages nent of h		1 Burial 2 Cremation 3	Removal from State	cemetery, crei	matory or other pla	A1	ıgust 3,	200. L	ocation - City of	TOWIT, State	
Ē	tmen tant:		4 Donation 5 Nother (Specify				ery	2006		ver Spri	ng, Mary	land
Bal	Depar Mpou mpou iny ir		21. Signature of Funeral Service Licen	500	Fi	ancis J.	es Collin	ns Funera	1 Hor	ne Inc.	- MD 20	2001
	40 E 4 0		23a. Part1. Enter the disease, or comp	Doday				lvd, W, S		spring	Approximate	
	Physician /Medical Examiner		shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Gastric Cano Due to (or as a consec							Interval Betwonset and D	
	cuted od ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):							
760,	ite be executed lysicien and he burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					Y.		
	F 5 6	dlcal		d					-			
	death certified attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	ıl déath 3	Ectopic pregnanc Other (specify)	у			23d. Date of del Month	•	'ear
ď	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	inderlying cause gi	en in Part I.	23e. Did	tobacco i	use contribute to	the cause of d	eath?
ds	uires that signed t Id be det	d by						10	Yes 2	□No 3□Pr	obabiy 4 🔀 L	Inknown
ecords	w requir been si should	Completed						24a. Wa	e an	24h Ware au	itaneu findinas	available
Re	The lay	E D						aut	opsy formed?	prior to death?	utopsy findings a completion of ca	ause of
<u></u>	n: The licate h r, page								2 <b>€</b> No		2 No	
Division of Vital	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	55.0	Ott		Death (Check only				
ō	Phys raidi	: To	1 ☐ Yes 21② No  27. Manner of Death		ER/Outpatier 28b. Time o	" 30 DON	7 [] [40] 511	ng Home 5 Res			city) Hospi	_ce
U Q	ding h. After funer	tion	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk?  Yes 2∐No			,		
S	Attending ir death. sctor: After by the fune	lica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, sti				(Street ar	nd Number or Ru	ural Route Num	ber.
<u>&gt;</u>	ē <b>5</b> 5 €	Certification;	4 Homicide	building, etc. (Specia	(y)	, , , , , , , , , , , , , , , , , , ,			òwn, State			
	To the Hospital (within 24 hours a To the Funeral Completely filled i	Medical	29a. Certifier (Check only one) TE Certifying Ph	ysician: To the best of my knowiner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and popinion, death	place, and due to the occurred at the time	e cause(s e, date and	) and manner as d place, and due	stated. to the cause(s	)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier			29c. Licens	se number			te signed (Mont		
)			Cynthia m.	Williams, D.	0-	400	5803	32	J	fuly 28,	2006	
	10					Print)				0 -		
			CYNTHA M WILLIAM	ns, O.O. MONTG	omery	HOSPICE	6001 MUN	CASTER MILL	Rd	Kockville	, MO 20	852
Å.	Sta Registr		30. Name and address of person who of CYN7thA M WILLIAN  31. Date filed (Month, Day, Year)  31. 2 (	32 Registrar's Signa	ture	andel						

State of Maryland / Department of Health and Mental Hygiene 2 () For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2006 July Year **Physician** Catherine O. Longe 29, 5:00  $A^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9624 Pastora Place Columbia Howard 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M &F unknown 71 Nigeria Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10b. County 1 Yes 2 No Director MD Howard Columbia the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ death with 9624 Pastora Place 21045 23a Nigeria Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 X No by Yas, Give Specify If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced "natural" atal Hygiene.

of other than "natural sevent, the Wedical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, ODGS. 17. Father's Name (First, Middle, Last) Be unknown Adigun unknown Nwaorie P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adejoke Ogungbesan/daughter 9624 Pastora Place Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Ellicott City, MD \* 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses M01442 Kadd 4112 Old Columbia Pk. Ellicott City, MD Vernil 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC CANCER **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Securatially list constants if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a Box 68760 Physician/Medical the as IF FEMALE use. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? page certificate 2. No 1 Yes 2√2 No 1 Tes ector. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2√2 No Medical Certification: To 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) th is 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the f 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t Hospitel 1 🗶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer MD D0060027 JULY 31 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORRIN DAVID MARTIN 5200 EASTERN AVENUE BALTZMORE, MARYLAND 21224 32. P Sgistrar's Signature 31. Date filed (Montt State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29d per doc 2858 8-15-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar		Ce	rtificate of		Re	g. No.	25/20
	Physici	an	Decedent's Name (First, Middle					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al		nee Montg	omery	# 01 T	1 1 1 1 1 1 1 1 1	August		4:30A M
?	Examin	er	4a. Facility Name (If not institution				or Location of Death		4c. County of Death Prince G	oorges
			Southern Ma 5. Social Security Number		D1τα⊥ ne (In yrs. last birthday		nton If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
l	Funeral Director		579-11-5381	1 □ M 2 🔀 F	34 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 2	24,1972 Coul	Wash.,DC
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			1	10d. Inside City Limits
	Maryl 4 sho	ō	Md. PG		Temple	Hille				Yes 2 No
	28a	Je C	10e. Street and Number		Tempie	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	death with the Maryland rns 23a or 28a-f show rmust be notified at	Funeral Director	2612 Afton S	Street		20	748	Ţ	United Sta	ates
	death	nerg	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp an, Mexican, Puerto		14. Race - Americ	can Indian,
215-0036	filed within 72 hours after death with the Marylan Hygiene. Ither then "natural", or Items 23a or 28a-f show int, The Madical Externing must be notified at		1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced		No	1 ☐ Yes 2 ☑ No		nican, etc.)	Black, White,	
5	2 ho	Completed by	15. Deceden	t's Education	16a. Dece	dent's Usual Occu	pation during most of work	1	6b. Kind of Business/In	
7	en "r	nple.	(Specify only higher Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use retire	during most or work d)	ang		
N	filed wi Hygien ther th	် ပ	12		Med	ical As:			Private	
yland	S d a D	Be	17. Father's Name (First, Middle,	Last)				e (First, Middle, M		
<u> </u>	should and Men marks umatic	2	Joe Montgome				Gwendo	-	ight	
Mar	T la		19a. Informant's Name/Relations						City or Town, State, Zip	(Code)
	as 1 and of Health Item 27 r other to		Gwendolyn Mo  20a, Method of Disposition	ntgomery/m	20b. Place of Disp	emple II: osition (Name of	on Stree	. 20748 Date 2	Oc. Location - City or To	own. State
saltimore,	Pages nent of int: If It iry or o		1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		сөтөгөгү, сге	matory`or other pla Hill CeI	C0)			
	permit. P Departme Importan eny injur		21. Signature of Funeral Service	m. e		2. Name and Addre			uitland, Edwards	
ñ	permit. Pages 1 Department of H Important: If Itel eny injury or ott		Danice)	Edima	1 )			_	uitland, M	
			23a. Part 1 Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do not en					Approximate Interval Between
	Physician	20 1	Immediate Cause (Final disease or condition	v					0	Onset and Death
•	/Medical		resulting in death)		a consequence of):	1 1 2				
	Examiner		Sequentially list conditions,	b. Hum		nmun	0 01	YUS		
	d H	iner	rany, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of).					
	death certificate be executed e ettending physician and d for use as the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for as	a consequence of):					
68/6U,	be ey			Due 10 (01 as	a consequence or,					
ģ	tifficate ng phys as the	Medical		d						
×	certii nding use a	₹ Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	erv
X D	death cer ettendin d for use	Physician/N	in the past 12 months?	4□Pregnant at		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
j.		hys	9 Unknown	9□ Unknown						
ν L	law requires that the de as been signed by the 2 should be detached	by P	Part II. Other significant condition	ons contributing to death b	ut not resulting in the u	ınderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
cords,	en sie	ed	Chronic C	198 ( ruc 1	ive ful	nondi	× DISE	≥ te 1□Yes	s 2 No 3 Prob	pably 4 Dunknown
Ü	lawr es be	Completed	Renzh	Faile	4 VZ			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u>r</u>	The cate h page	S	Pzner	2,11150	- Pn	eums	xsrchi	performe 1 ☐ Yes 2	ed? death?	2K No
VII	sicien: The law certificate hes t irector, page 2 s	Be	25. Was case referred to medica examiner?					h (Check only one	)	
0	Physic this c	2	1 Yes 2 No	Hospital:		III OLI BOX			nce 6 ☐Other (Specif	y)
5	ding After funer	ē	27. Manne of Death 1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investi		ry 28b. Time o y Year) Injury	Wo	rk?  Yes 2 ∐No	28d. Describe how	w injury occurred	
UNISION	Attending Physicien: or death. sctor: After this certific by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Ini	ury - At home, farm, st		1.00 2	28f. Location (Stre	eet and Number or Rura	ul Route Number
2	efter efter Dirs	ert	4 Homicide	building, et	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,		
	To the Hospital or Attending Physicien: within 24 hours effer death.  To the Funeral Director: Affer this certific compietely filled in by the funeral director.	edical C	(Check only 2   Medical	g Physician: To the best Examiner: On the basis o	f examination and/or in	th occurred at the ti	me, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as si te and place, and due to	ated.  the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifie	and manner sta	ated.	29c. Licens			d. Date signed (Month,	
	T W T		and the contract	T 00	110	7	1922	9 1	0 8 - 0 7	06
			30. Name and address of person	who completed cause of	e 1 17	Print)	1 1 9 0	1	00-07-	<del>5 5 -</del>
			Talka C	who completed cause of a	137 F	C in 1	hern	AUP S	E De	2 0022
	Sta	te	31. Date filed (Month, Bay, Year)		ar's Signature	204	NEND		, ,,	20036

Registrar

	,	1 - For State Registrar	State of Maryl			nt of Health te of Deat			Reg. No.	2006	25721
Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of De.	Day	Yeer	3. Time of Death
/Medic	al	Bernard V. Micha 4a. Facility Name (If not institution, give s			4b Cib	, Town, or Location	on of Death	VUL7	26 4c.C	2006 Sounty of Deat	
Examin	er	FutureCare Chesi			40. Cit	Arnold	on or beaut			Anne A	
Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birth		er 1 Year   If Und	der 24 Hrs.	8. Date of Birt	b		hplace (State or Foreign ountry)
Director		214-18-7837 <sup>183</sup>	M 2□F 8	5 Y	rs. Months	Days Hour	rs Min.	Jan. 7	, 192	1	MD
p >		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town	or Location						10d. Inside City Limits
shov	5	MD Anne Ar		. Ony, rown	or coodion	Arno	ld				1 ☐ Yes 2 ☑ No
286-f	Funeral Director	10e. Street and Number			10f. Z	ip Code			10g. Citize	en of What Co	ountry?
with 3a or		1008 Deep Creek A	venue			21012				US	7
death	Jera		2. Was Decedent Ever	in U.S.	13. Was Dec	edent of Hispanic ecity Cuban, Mexi	Origin? (Spe	cify Yes or No	- 14	4. Race - Ame	erican Indian,
or ite	Ē	1 ☐ Never Married 2 Married	Armed Forces? 1 XYes 2 ☐ No If Yes, Give	wwii		ecity Cuban, Mexi		rican, etc.)		Black, White Specify: W	hite
filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or items 23s or 28s-f show ent, the Medical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:								
nett	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(	Decedent's Us (Give kind of v life. DO NOT	ual Occupation rork done during m use retired)	nost of workii	ng	16b. Kind	d of Business/	Industry
withir ene. then	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)			lectricia	an			BG 8	& E
filed Hygi other	0	17. Father's Name (First, Middle, Last)				18. Mo	other's Name	(First, Middle,	Maiden S	iumame)	
buld be Mental arked o	To B	Earl Michael				Be	ernade	tte			
s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. If the 71 is marked other than "neturat", or items 23a or 28e-f show other traumatic event, I'm Medical Examinat must be notified at	-	19a. Informant's Name/Relationship (Typ			_	ss (Street and Nur					Zip Code)
and and lealth m 27 m		Dorothy M. Michael,		-		ep Creek					012
1 of H		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Po	emoval from State	cemetery	Disposition (N	other place)		28 -		ation - City or	
tmen tmen tant:		4 □Donation 5 □ Other (Specify)		Metro	Cremat	_	July			imore,	
permit. Pages Department of himportant: If ite eny injury or of once.		21. Signature of Suneral Service License	00		Barra	nco & soi	ns, P.	A. Seve	erna I	Park Fi	uneral Home
	~	23a. Pm11. Enter the disease, or compli	cations that caused the	death. Do no		OV. Ritch ode of dying, such				Park,	Approximate
Dissolution		shock, or heart failure. List only on Immediate Cause (Final									Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a cor			omM					
Examiner		Conventially list conditions									
D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsaqueinna o	n:					1	
be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	. Due to (or as a cor	seguance o	f)·						
w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	cal E		Due to (or as a cor	1304401100	.,.						
ificate g phys	0000										
ath certifica sttending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr						23	3d. Date of de	livery
death death ele etten	Icia	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time		3 □Ectopic 5 □ Other (					Month	Day Year
tt the by the tache	hys	9 Unknown	9□ Unknown					-			
requires that the	by P	Part II. Other significant conditions con	tributing to death but no	t resulting in	the underlying	cause given in Pa	art I.	1			o the cause of death?
law requires as been sign 2 should be	ted							''	Yes 2	No 3□Pr	robably 4 Unknown
law l has b	ompleted				-			24a. Was auto	osy	prior to	utopsy findings available completion of cause of
Th ate pag	S							1 ☐ Yes	2 No	death?	2 □ No
Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Other		(Check only o			
Phys this al dii	- T	1 Yes 2 No	1 ☐ Inpatient  28a. Date of Injury	2 ER/Out		28c. Injury at Work?		me 5 Resi			ocify)
ding Phy th. After thi funeral	cation:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea		njury M	Work? 1 ☐ Yes 2					
l or Attending after death. Director: After d in by the funer	fica	3 Suicide 6 Could not be	28e. Place of Injury	At home, far	m, street, fact	ory, office				Number or Ri	ural Route Number,
	Certifi	4 Homicide	building, etc. (S)	рыспу)				City or To	wn, State)		
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: K completely filled in by the It	edicai (	(Check only 2 Medical Examin	sician: To the best of my ner: On the basis of exa and manner stated.	mination and	t/or investigati	on, in my opinion,	death occurr	ed at the time,	date and p	place, and due	e to the cause(s)
To the P within 2 To the Complet	Me	29b. Signature and tule of certifier			2	9c. License numb	per		29d. Date	signed (Mont	th, Day, Year)
		Moneg	MD			D575	531	1	JUL	7 27	7,2006
		30. Name and address of phone who co	impleted cause of death	(Item 23a) (	Type, Print)	1	. 6.0				
		Mohit Neg 860	of Veteray	ns Hu	sy, sui	te 204,	MILLE	rsville	- , /	us 21	1108
Sta Regist	ate rar	30. Name and address of partin who compared to the state of the state	006 Sz. gistrar's S	Signature	Sport	E .					

		•	For State Registrar	State of Marylar			nt of Healti te of Dea			iene g. No.	06	25722
	Physici		1. Decedent's Name (First, Middle, Last) Ricky	Alan		Met	tv		2. Date of Deat Month August	Day	Year	3. Time of Death 8:55 A M
	/Medio Examin		4a. Facility Name (If not institution, give s				, Town, or Location		11uBub o	<del></del>	nty of Death	0.95 K
			12411 Fort Cumber  5. Social Security Number 6. Sex				Cumberla		8. Date of Birth		Allega 9. Birtho	any lace (State or Foreign
ď1	Funeral Director		215-56-8481 <sup>1</sup> X	M 2□F 52	Yrs.	Months	Days Hou	rs Min.	(Month, Day, 03/03/19	Year)	Coun	land
	yland		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					11	Od. Inside City Limits
	Ba-1 e	Director	MD Alleg	any		7	berland			0.00	-/	1 ☐ Yes 2 No
	3a or 2		10e. Street and Number 12411 Fort Cumbe	nland Daire	Q F	101. 2	ip Code 21502		1	ug. Citizen d USA	of What Coun	try?
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-f ehow ha Marical Examinar must be notified at	by Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Dec If Yes, sp	edent of Hispanic ecify Cuban, Mex	Origin? (Spe ican, Puerto f	cify Yes or No- Rican, etc.)	14. F	lace - Americ Black, White, o	
036	ral', or	1 by F	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates:		1 🗆 Yes	2∑ No Spec	city:		Spe	cify: Wh	ite
21215-0036	in 72 ho n "natu fedical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of w	ual Occupation ork done during ruse retired)	most of workir	ng	16b. Kind of	Business/Inc	dustry
212	ed with rgiene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		Truc	k Driver				erage	
Maryland	d be fill ental H ced oth	To Be	17. Father's Name (First, Middle, Last)  James  A	lan i	Metty			other's Name Betty	(First, Middle, M	<i>l</i> aiden Sum izabe		Cook
ary	and Me	Ĕ	19a. Informant's Name/Relationship (Type			ng Addre	ss (Street and Nu	mber or Rura	Route Number	City or Tov	vn, State, Zip	Code)
e, S	1 and 2 Health om 27 I	ļ	Heler V. Metty / 20a. Method of Disposition	wife 20b.	12411	For	t Cumber				umberl	and, MD2150
Mor	Pages ent of h nt: if Ite ry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation_ 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, crem tris Men		other place) 1 Cemet	1			ıberlan	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-1 show any injury or other traumatic event, tha Madical Examinat must be notified at once.		21. Signature of Furieral Service License	and the same of th	22	2. Name	and Address of Fa	acility Ada	ams Fami	ily Fu	neral	Home, P.A.
	7		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the deale cause on each line.	th. Do not ent	er the mo	de of dying, such	as cardiac o	r respiratory arre	est,	riar y re	Approximate Interval Between
14	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	Pancreatic Due to (or as a consec							•	Conset and Death  1 year
1.0	Examiner		Sequentially list conditions	Due to (or as a consec	(uence or):							
	ted nsit	Examiner	Sequentially list conditions, it any, leading to him diate cause. Enter Underlying Cause (Disease or injury	Due to (or as a noneed	uanea of):							
60,	icate be executed physicien and s the burial-transit	i Exal	that initiated events cresulting in death) Last	Due to (or as a consec	quence of);							
68760,		edicai										
O. Box	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Pete 4 Pregnant at time of c 9 Unknown	ıl death 3 [	Ectopic Other (	pregnancy specify)				Date of delive Month	ry Day Year
ds, P.O.	uires that t n signed by lid be detai	Ď	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying	cause given in Pa	art I.				e cause of death?
Division of Vital Records,	The law requir ste has been si bage 2 should	Completed							24a. Was ar autops perform	y ned?	prior to con death?	psy findings available inpletion of cause of 2 No
/ita	hysician: The la his certificete ha: t director, page 2	Be	25. Was case referred to medical examiner?					lace of Death	(Check only on			
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Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)				8f. Location (St. City or Town		mber or Rura	l Route Number,
	ne Hospit 24 hour: ne Funers	Medical C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best of my known to the basis of examination and manner stated.	owledge, death ation and/or in	h occurre vestigation	d at the time, date in, in my opinion,	e and place, a death occurre	and due to the ca	use(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
		ž	29b. Signature and title of separtion	111		2	oc. License numb		25	9d. Date sig	ned (Month, I	Day, Year)
,	10		30. Name and address of person who co						LaVala	MD	21502	)
9	n Ka Sta	te	31. Date filed (Month, Day, Year)	Channa, M.D.,  Registrar's Sign			ional Hi	giiway,	та мате	, ויווט	21502	
	Regist		AUG 0 7 2006	See L	A SOUTH	Mary .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1006

Physician Middloa Examiner  4. Security Was Interested to the Security of the		t	•	For State Registrar	State of Ma	aryland			te of Dea		ieniai n	Reg.		lui W	1 5 0
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Top State   Top County   Top	1	Director	-			86	113.				April	19	1920	Marylan	<u>d</u>
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29a. Certifier (Chack only one)  29b. Signature and title of certifier  29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1. Bolkfallo (550 ORical) ST km 453 Balimore M2 21231	<b>&gt;</b>	ysic nis ce direc	0		Hospital: 1  Inpatie	nt 2 🗆 E	R/Outpatier	nt 3 🗆 🛭	OOA Other: 4	☐ Nursing Ho	me 5. Re	esidenc	e 6 Other (Sp	ecify)	
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	8			31. Date filed (Month, Day, Year)	4 2006 32. Registra	ar's Signatu	10 As A	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charlotte Miller July 28, 2006 9:30P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2**X** F Director 297 05 5179 86 Oct 16, 1919 Canton, Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Direct Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? llll University Blvd. West #410 20902 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Ashur Miller Anna Rudner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Levin / Daughter 1504 Highland Drive Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State King David Mem Gdns 7/30/2006 Falls Church, Virginia 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Rines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 231. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 12 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificete hes l lirector, page 2 s 24a. Was an autopsy performed? 1 Yes 2000 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation Injury 1 Yes 2 No Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e 1 \*\*XCertifying Physician: To the best of my knowledge, death construct at the time, date and place, and due to the nauce(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0061462 7/28/06 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ghen Rd, Silver spring, Irfan Khan 1500 Forest MO 32. gistrar's Signature 31. Date filed (Month, Day, Year) State AUG 01 2006 Registrar

06-05426

Please Type or Print in Black Indelible Ink

Solomon Aaron Major State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Date of Death Time of Deat Physician/ Month Yea 2301 hrs Medical Examiner July 25, 2006 Solomon Aaron 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1c. County of Death S/B Rt 210 @ I-295 ramp Fort Washington Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 578-02-5063 Country) 09/19/1977 1 X M 28 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County any 1 X Yes 2 No 28a-f show MD Oxon Hill Prince Georges notified at once. 10e. Street and Number 10g. Citizen of What Country  $\Box$ 522 Wilson Bridge Drive #B2 20745 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black lant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married 2 X Married Armed Forces' 2 X No Yes Widowed Divorced If Yes, Give Year Yes 2 X No specify Specify: Black þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 and Mental Hygiene MD 21215-0036 Salesperson Pvt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margurite Lundy Solomon W. Major ages I and 2 should be nt of Health and Ments 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Wilson Bridge Dr., #B2, Oxon Hill, MD Tiffanie Major/Wife 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Baltimore, washington National Cereter 1 X Burial 2 Cremation 3 Suitland, Maryland permit Page Department mportant: 2,2006 Other Specify Aug. Donation 5 21. Signature of Funeral Servi 22. Name and Address of FacilityAustin/Royster Funeral Home 3821 14th Street, N.W, Washington, DC 20011 Part I. Enjer the disease, or complications that seased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure List only one cause on each line. Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED #200,coerFH8/1/06,BMW,McCc After this certificate has heen signed by the attending physician : uneral director, page 2 should be detached for use as the burial -Division of Vital Records, P.O. Box 68760, IF FFMALE 23d Date of delivery 23c. If yes, outcome of pregnancy Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: æ Other 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ဥ **✓** Yes 28a Date of Injury Jul 25, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Pedestrian struck by auto Natura 5 Pending Yes 2 ✔ No death the Funeral Director: the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be or Town, State) S/B Rt.210 @ I-295 ramp, Ft. Washington, MD (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E July 26, 2006 mis 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signatur State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

AUG

			For State Registrar	State of Marylar		irtment of H tificate of I			iene <sub>eg. No.</sub> 20	06	25726
			Decedent's Name (First, Middle, Last)					2. Date of Deat		V	3. Time of Death
	Physicia		Doris Mandelba	um				July 29	Day 2006	Year	7:50 p <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
*	Examin	•	Wilson Healthcare	Center		Gaither	sburg		Mont	gomer	У
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthple Count	ece (State or Foreign
	Director		135-12-1880	M 200 F 87	Yrs.	Worters Days	Tiours issue.	SEP 14,	1918		ersey
	<b>D</b> •	}	Usual Residence of Decedent  10a. State 10b. County	100 Ci	ty, Town or Lo	nation		····		10	d. Inside City Limits
	aryla shov	_	,							1	1 ∰Yes 2 ☐ No
	he M 18a-1	Director	Maryland   Montgomer	y Gai	thersbu	10f. Zip Code			0g. Citizen of W	Ihat Caust	71
	with	흡				20877		1	United :		
	ss 23	era	405 Russell Avenue	2. Was Decedent Ever in U	S 13 V		spanic Origin? (Sc			- America	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury poolther traumatte event, the Meulcal Evanirar must be notified at once.	by Funerai	1 □ Never Married 2 □ Married 3 ₺ Widowed 4 □ Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ☐ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black	k, White, e	etc.
ဝို	2 hou atura	led	15. Decedent's Educ	ation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Bu	siness/Ind	ustry
212	hin 7:	Completed	(Specify only highest grade	Completed) College (1-4or 5+)	life. I	kind of work done of OO NOT use retired	during most of won ()	ang			
21	d with	E C	12		Home	maker			Own Hor		
멀	al Hy l other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, I	Maiden Sumame	э)	
<u> a</u>	Ment Ment srke	2	Benjamin Lefko	owitz			Lillian	Mos	kowitz		
a	2 sho and is m		19a. Informant's Name/Relationship (Type	oe, Print)	1	g Address (Street a					Code)
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Baltimore, Maryland 21215-0036	permit Depar Impor any in		21. Signature of Funeral Service License	M009	56 L	ouis Subu 3-01 Broa	rban Cha dway. Fa	pels, In ir Lawn.	NJ 074	10	
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ds, P			Part II. Dther significant conditions con	tributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.			ibute to the	e cause of death?
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Vital		a)	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 th (Check only on		163	20,140
$\geq$	Physician: rthis certific ral director,	O.B	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	ar /	ome 5 Reside		r (Specify	)
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Ö	Attending it death.  ector: After by the fune	atic	2 Accident investigation				Yes 2 □ No				
.=	l or Att after de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	(Check only 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin							
	ro the vithin 2 or the omplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licanso	e number	2	9d. Date signed	(Month, E	Day, Year)
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	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 1 201	Registrar's Sign	ature -	reles	* 1				

			For State	State of Maryland		artment of H			000	
			Registrar  1. Decedent's Name (First, Middle, La	ast)	061	incate of L	- Call	2. Date of Deat	ng. No.	3. Time of Death
	Physici		Sava E	la a				Month	Day Year	a laca M
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or	Location of Dea	th	4c. County of Dear	
1	Examin	е	Shady Grove A	thought Howar	11	Rock	villein	20	Monta	mer
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	Director		214-32-9995	<sup>1□ M</sup> <sup>2</sup> √ F 70	Yrs.	Months Days	Hours Mir	Nov. 20		ryland
	р. <b>"</b>		Usual Residence of Decedent	10- 6:	. T					40d Inside City Limite
	anylar ehov	_	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√ No
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	with th	2	10e. Street and Number	. D J		10f. Zip Code	882	"	Og. Citizen of What Co U.S.A.	ountry?
	n 72 hours after death with the Maryland "natural", or Items 23a or 28s-f ehow solical Examinal must be incitited at	Funeral Director	23915 Log Hous	12. Was Decedent Ever in U.	S 13 5	l		Specify Ves or No-	14. Race - Ame	erican Indian
	iten d	Ĕ	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	.5.	Was Decedent of His f Yes, specify Cubar	n, Mexican, Pue	nto Rican, etc.)	Black, Whit	
99	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2√√2 No	Specify:		Specify:	ite
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2	77	Completed		5+	Tea	cher		P	ublic Scho	ols
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yla	should be nd Mental marked c	2	James Edward	Welsh			Genev		nch	
Maryland	2 sh and le m		19a. Informant's Name/Relationship		1					Zip Code) 20882
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ō	0 = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Memoval itom State		sition (Name of natory or other place	1		•	
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Bal	permit. Pag Department Important: eny injury once.		21. Signature of Fun ral Service Lice	hilliams	Mc 26	lesworth- 401 Ridge	-Willian Road,	ns P.A., I Damascus	uneral Hor Maryland	ne I 20872
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death	h. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory arre	est,	Approximate Interval Between
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	si ad	ine	Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury	Due to for as a cons sol	uence of					
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	uance of):					
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	icate phys s the	Physician/Medical		_ d						
9 x	n certific anding p use as	W/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	incy				23d. Date of de	livery
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	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ğ	w require been sig should b							1 □ Y€	s 2 No 3 P	robably 4 Winknown
00	aw re is be 2 sho	piet						24a. Was a		utopsy findings available completion of cause of
Vital Records,	The lay	Completed						_ perform		
ita	ien: artifica ctor,	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only on		
of V	Physicien: r this certific ral director,	2	1 ☐ Yes 2 X No		ER/Outpatier		4 1 Nursing	Home 5□ Reside	nce 6 Other (Spe	city)
	ding Ph h. After th funeral	on:	27. Manuer of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work		28d. Describe ho	w injury occurred	
sio	Attending in death.	cati	2 Accident investigation 3 Suicide 6 Could not	ho -			/es 2 □No			
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	To the Hoepital or within 24 hours after To the Funeral Discompletely filled in	edical (	29a. Certifier Certifying P (Check only 2 Medical Exa	Physician: To the best of my kno- aminer: On the basis of examinal and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and man <i>n</i> er a ate and place, and due	s stated. e to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mont	h, Day, Year)
			Pompen	tu MO		645	02		7/30/04	
	25		30. Name and address of person who		n 23a) (Type,				1. 10 3	
			Brian Carpen			cal Center	r Drive	Rockvill	e, Marylan	nd 20850
	Sta Regist		31. Date filed (Month, Day, Year)	2006 32. Figistrar's Signa	iture	house				

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	/Medic	al	4a. Facility Name (If not institut	ion, aive s	treet and num	nber)			Town, or	Location of	of Death	July	31, 4c.	2006 County of		5:00 A. <sup>™</sup>
Fig.	Examin	ei	217 East 2nd	Stre	et			Free	lerio	k			Fre	ederi	.ck	
	Funeral		5. Social Security Number <b>224–60–9165</b>	6. Sex		7. Age (In yrs.	last birthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	rth ay, Year)		Coun	ace (State or Foreign try)
-	Director		Usual Residence of Decedent			62	115.	l				July 1	1, 19	144	Nort	ch Carolina
	yland		10a. State 10b. Cour	*		10c. Cit	y, Town or Lo		_						10	Od. Inside City Limits
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	vith th	Director	10e. Street and Number		_			10f. Zij	Code	. 1				en of Wh		•
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ğ	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow the Madical Exacilmer court be notified at	d by	3 Widowed 4 Divord		If Yes, Giv Year or Da	ites:										
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Maryland 21215-0036	C1 62 70 00		19a. Informant's Name/Relation  Dennis Massie		_			-				Route Numberick,			ate, Zip	Code)
	of Health item 27 other tr		20a. Method of Disposition	, -		20b. F	Place of Disponentery, cre	osition (Na	me of	1		ate	-	cation - Ci	ty or To	wn, State
Baltimore,	permit. Pages Department of I Important: If Ite eny injury or of		1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		lemoval from S		ederic	k Cre	emato	ry 8	3/2/2	2006				Maryland
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	e deat	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			ant at time of o		Other (s						Mont	1	Day Year
P.0	that the de led by the a detached		Part II. Other significant cond	litions co	ntributing to de	eath but not res	sulting in the t	underlying	cause giv	en in Part I		23e. Did	tobacco u	se contrib	ute to th	ne cause of death?
Vital Records,	9 Pg 90	d by										1 🗆	Yes 2	□No 3	☐ Prob	ably 4 Unknown
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Ä	The lav	E OC										per	formed?	de	ath?	2 No
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of	두 두 교	. To	1 Yes 2 No		Hospital: 1 ☐ I 28a. Date		ER/Outpatie			4 🗆 NI	-	me 5 🙀 Re: 28d. Describe				v)
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Ö	ital or A															
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Me	29b. Signature and title of cer	ifier						e number				-		Day, Year)
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0.0			JUSTINI 31 Date filed (Month Day Yo	AV)	NGY 32. F	gistrar's Sign	ature	D	4	101	Hi	1500	torn	rko	1	Alan VA
	Regist	ate rar	31. Date filed (Month, Day You	0 1 2	006	leve	N. A	freel								

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		•	1- State of Maryland / Dep	artment of Health ar	nd Mental H	ygiene 2000	25729
	Dhyoisir		1. Decedent's Name (First, Middle, Last)		2. Date of I	Death Day Year	3. Time of Death
	Physicia /Medic		Robert Charles Metzler		Ju1y		7:30 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of	Death	4c. County of Dea	ith
			774 Dividing Road	Severna Park	4 Hrs   0 D4 F	Anne Aru	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 179-32-1193 66 Yrs.	Months Days Hours	Min. Feb. 1	5, 1940 Peni	thplace (State or Foreign ountry) nsv1vania
	Director		Usual Residence of Decedent		100. 1	3, 1540 1011	
	yland now	1	10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mar	ţċ	Maryland Anne Arundel Severna P	ark			1 ☐ Yes 2 🛣 No
	or 28	le	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	23a c	Funeral Director	774 Dividing Road	21146		USA	
	ee	iner.	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	in? (Specify Yes or f Puerto Rican, etc.)	No- 14. Race - Am Black, Whi	
36	filed within 72 hours after deeth with the Maryland Hygiene. ther than "natural", or fleme 23a or 28a-f ehow ent, the Madical Examinar must be notified at	by Ft	1 ☐ Never Married 21∑ Married 1 ☐ Yes 2 2☐ No ☐ If Yes, Give	1 ☐ Yes 2 No Specify:		Sacrifu .	nite
Ö	tural'	8	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business	
<u> </u>	n 72 "na"	jet	(Specify only highest grade completed) (Giv	e kind of work done during most ( DO NOT use retired)	of working	100. Killd of Business	unidustry
12	withi iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Teach	er		Education	
ğ	i Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother	s Name (First, Midd	lle, Maiden Sumame)	
lar	uid by Menta riked ritc e	To E	John Paul Metzler	Ruth	Everna Mo	rton	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be coulded at once.			ling Address (Street and Number Dividing Road S			
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Balt	permit. Depart import any in			2 Name and Address of Facility O'Ing Home Crema everly L. Heckr			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as c	ardiac or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	^			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1 11			
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	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	U			
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m	that the death certific ed by the ettending p detached for use as	Physician/Med	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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	8 6 9	þ	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		d tobacco use contribute t ☐ Yes 2 ☐ No 3 ☐ F	robably 4 Unknown
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alF	n: Th icete r. pag		obesity hypertensin	^	1 ☐ Yes	20 No 1 □ Ye	
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o	ar this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time			e how injury occurred	scny)
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Ö	rs after or ei Dir	Cer				,	- 1
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, dei  (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death	place, and due to the occurred at the time	ne cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	29c. License number	V	29d. Date signed (Mon	th, Day, Year)
,			· WWW/WYUUU	09980	7	1-31-06	>
2)	02-		30. Name and address of person who completed cause of death (Item 23a) (Type Kairin in Madge MD 8028	D4480 Pikhie Hury	Smite 13	1 Pasadena	MOZIIZ
	Sta Registr		31. Date filled (Month, Day, Year)  AUG 0 1 2006  32. Figistrar's Signature	back			

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:00 P M July 30 2006 Josephine D. McManus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1629 Andylin Way Sykesville Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F Nov 9, 1920 Pennsylvania 181 14 8491 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State rel', or Items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Carroll Sykesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1629 Andylin Way 21784 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene. and I stem of Health and Mental Hygiene. It item 27 is marked other than "naturel", or flee traumatic event, the Medical Examinary or other traumatic event, the Medical Examinating or other traumatic event, the Medical Examinating or other traumatic event, the Medical Examination. 1 □ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify à 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Volpe Barbara Laurita 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol J. Cappelletti/Daughter 1629 Andylin Way Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 8-3-2006 Sykesville, MD Lakeview Mem. Park ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ancer **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2X No Month detached for Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed ģ 3 ☐ Probably 4 ☑ Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature a 16 August 1, 2006 of death (Item 23a) (Type, Print) 30. Name and a ress WAY Stelly 380 State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 257Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Yeer **Physician** Northcraft Theodore Kenneth 2006 8:58 P August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg Village Nursing Home Allegany Frostburg If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Months 1 1 M 2 □ F 184-16-0988 06/28/1921 Director Pennsylvania Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b County worle rthan "natural", or items 23a or 28e-f ehov the Wedical Examiner must be notified at 1 ☐ Yes 2 🎇 No Cumberland Funeral Director MD Allegany 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 15603 Packard Drive 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Be Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) Machine Operator 8 Construction treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be inent of Health and Mental I set: If item 27 is marked o Northcraft Russell Eunice Ruby 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) nt of Health a : If item 27 is or other tree Kenneth E. Northcraft / son 15602 Winslow Street, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. Fairview Christian Cem. 08/07/2006 \* 4 ☐ Donation 5 ☐ Other (Specify) Inglesmith, PA 21. Signatu s of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORONARY Soul 10 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the th 9 🗆 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Fibrillohm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page ; certificate 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ë 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after death. Il Director: After the 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel To the Funeral 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier D26907 August 3, 2006 Herdh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Drive, Cumberland, Maryland 2/10 Harjit Sidhu, M.D., 31. Date filed (Month, Day, Year) AUG 0 3 2006 2. Registrar's Signature State Registrar

			1 - For State Registrar	Sta	ite of M	larylan				ealth a			Reg. No	200	6	257	132
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	/Medic		Clara M.		Noba							July			D 11	11:30	) Рм
<i>}</i>	Examin	er	4a. Facility Name (If not institution	_	and number	)				Location of			40	. County of M		aomorii.	
			9801 McMillan  5. Social Security Number	6. Sex	7 A	ge (In vrs.	last birthday)		r 1 Year	pring		8. Date of Bir	th	9		gomery	
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	eath	by Funeral	11. Marital Status		as Deceden	t Ever in U	.S. 13.	Was Dec			igin? (Spe	cify Yes or No	-	14. Race -		an Indian,	
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2	lled v lygie ther t	ပိ	1.2 17. Father's Name (First, Middle,	l astl			Exe	Cuti	ve se	creta		(First, Middle			GOV	ernmen	L
and	d be f	o Be	William Muhlh									Helwi		,			
2	Shoul nd Me mark	၉	19a. Informant's Name/Relations	nip (Type, Pr	int)		19b. Maili	ng Addre	s (Street a	and Numbe	ər or Rura	l Route Numb	er, City	or Town, St	ate, Zip	Code)	
ž	alth a alth a 27 is		Winfried A. No	back/	Husbai	nd	9801	McM	illan	Aven	nue,	Silver	Spr	ing,M	D 2	0910	
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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then 'natural', or iteme 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service	Licensee	Oe,	,	F 5	2. Name ranc: 00 U:	nd Address is J. niver	ss of Facility COll sity	ty lins Bl <b>v</b> d	Funeral	l Ho	me In r Spr	c inq	,MD 20	901
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	1.0		30. Name and address of person							15	71		000	00			
			Steven Kariya	, M.D		1 Geo:			_	15, N	vneat	on, MD	209	02			
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			Decedent's Name (First, Middle, Last)						2. Date of Dea Month		Year	3. Time of	
	Physicia /Medic		Aleah Grace Pollack						July	22,	2006	12:20	) p <sup>M</sup>
	Examin		a. Facility Name (If not institution, give street and number)				Location of			4c. Cou	nty of Death		
			Holy Cross Hospital				Spri				ntgome		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under Months	Days	If Under	Min.	B. Date of Birth (Month, Day [uly 20]	Year)	Cour	place (State or	r Foreign
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21215-0036	tiled within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Medical Exeminer must be mutified at	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed)	16a Dece (Give	dent's Usua kind of wo DO NOT us	nk done o	ation during mos	at of workin	g	16b. Kind o	f Business/In	dustry	
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and	be fi	Be	Carl Joseph Pollack						izabet				
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Maryland	d 2 st th and 7 is r traur		Carl J. Pollack / Father		_				; Bowi				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.			Place of Dispo	osition (Nar	ne of	1	_	ate		on - City or T		
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	To the Hospitel or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1 ★ Certifying Physicien: To the best of my k 2 ★ Medical Examiner: On the basis of examinand manner stated.	nowledge, dea nation and/or i	ith occurred nvestigation	l at the tir n, in my o	ne, date ai pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s	s)
	omple	Me	29b. Signature and title of certifier		29	c. Licens	e number			29d. Date si	gned (Month	Day, Year)	
de	- 3 F 0		) ( long 15	>		D055	515			7/22/	2006		
4			30. Name and address of person who completed cause of death (It	em 23a) (Type									
			Andrea Lotze, M.D. 1500 H	orest	Glen	Road	; Sil	Lver S	Spring,	MD 20	910		
		ate	31. Date filed (Month, Day, Year)  AUG 0 1 2006  32 Registrar's Sig	nature	serve)								
	Regist	rar	AUG 0 1 2008		THE PARTY NAMED IN								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month **Physician** July 28, A M 4:00 Dorothy Mary Peters /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Springbrook Adventist Nursing Silver Spring Montgomery 9. Birthplace (State or Foreign Country)
Wash. D.C. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 13, 1917 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🗓 F 89 579-07-9294 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County e filed within 72 hours after death with the Marylan al Hygiene then "naturel", or Iteme 23e or 28e-1 ehow to the title Medicae Examinar must be notified all went, the Medicae Examinar must be notified at 1X Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20910 United States 12325 New Hampshire Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I □ Yes 2 1 No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ African American 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) D.C. Government D.C. Board of Elections of Health and Mental Hygie litem 27 ie marked other i r other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: if item 27 ie marked of Della (unknown) Jessie Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5507 Decatur St., Bladensburg, MD Ronald A. Peters (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State ö 8/3/06 Maryland National Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) njuch 22. Name and Address of FacilityMcGuire Funeral Service 21. Signature of Funeral Service Incensee any ir 7400 Georgia Ave. N.W., Wash. D.C. Part. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE disease or condition resulting in death) RENA DISEASE /Medical Due to (or as a consequence of) Examiner بتطارضته إحمد FAILURE THRIVE Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner g physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed week PLEURIL resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably ♣ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2.00 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only ÷ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-17874 7-28-0

Registrar

5

Baltimore, Maryland 21215-0036

P.O. Box 68760,

DHMH 17 Rev 1/2001

State

V1-51

Sankaran Nayar, M.D.

AUG 0.1

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Pagistrar's Signature

3717 38th Ave., Brentwood, MD 00002-0722

			For State Registrar	State o	of Mary	rland / Dep Ce		t of Head		nd Me		giene Reg. No.	200	6	2573	35
	Physicia	an I	1. Decedent's Name (First, Middle, I							-	Date of De	Day	006 Ye	ar	3. Time of Deat 9:30 A	h M
	/Medic	al .	Margaret Loui  4a. Facility Name (If not institution, s				4b. City	Town, or Lo	ocation of		July 2		County of D	eath	9:30 A	
	Examin		6015 Yeagertown F		,		New	Market	-				ederi	ck		
	Funeral Director		5. Social Security Number 6 220-40-5663	Sex 1 □ M 2 □ XF	7. Age (II	n yrs. last birthda 62 Yrs.	y) If Unde Months		Hours	4 Hrs. 8. Min. Ju	Date of Bir (Month, Da ine 10	y Year)	9. 44 M	Birthpla Counti ary	ace (State or Ford y) Land	aign
	and W		Usual Residence of Decedent  10a. State 10b. County		10	c. City, Town or	Location							10	d. Inside City Lin	nıts
	Maryi	to	Maryland Frederi	Lck	$\mathbf{F}$	rederick									1X Yes 2□	No
	th the	Directo	10e. Street and Number				10f. Z	Code					en of What	Count	ry?	
	deeth with the Maryland ms 23a or 28a-f show r must be notified at	rai	5991 Ladd Court #			15.116 A	217		i - Osiai	-2 (Casai	tu Van er Ne	USA	4. Race - A	marica	n Indian	
	n 72 hours after deeth with the Marylan "natural", or tems 23a or 28a-1 show tedical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Dec Armed Fo d 1 Tes If Yes, Gi Year or D	orces? 2 X No	ir in U.S. 13	If Yes, spi	city Cuban,	anic Origi Mexican, S <i>pecify:</i>	Puerto Ric	ly Yes or No can, etc.)		Black, V	/hite, e	tc.	
2-003e	tural'		3 ☐ Widowed 4 🏋 Divorced  15. Decedent's	Education		16a. De	edent's Us	al Occupation	on				nd of Busine			****
ĊĮZ	within 72 lene. than "na ne Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(1-4or 5+)	(Gi	ve kind of w . DO NOT	ork done dur ise retired)	ing most o	of working						
N		Com	8			Wait	ress		2 14-45-4	1- N (1	Cinca Scientific		taura	nt		
yland	Z a b €	Be	17. Father's Name (First, Middle, La George Finney Pri								First, Middle Louise					
	s 1 and 2 should if Health and Men Itam 27 la marke other traumatic	Ĕ	19a. Informant's Name/Relationship	p (Type, Print)							Route Numb				Code)	
Mar	and 2 salth a n 27 la		Lori Ann Keeney/d	laughter		1			n Roa	ad Nev	w Mark					
Baltimore,	jes 1 an of Heal If Itam 2 or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	B □Removal from	State	20b. Place of Dis cemetery, c	position (Na rematory or	me of other place)		Dat			cation · City			
	t. Pages rtment of rtant: If it		4 ☐Donation 5 ☐ Other (Special Service b)	ecify)		Chesapea			1				svill			_
a C	permit. Pages Department of I Important: If its any injury or o once.		21. Signature of Furieral Service of	He at	// 10. м						Servi				/84 , MD 210	)29
i			23a. Part1. Enter the disease, or co	omplications that	caused the	e death. Do not	enter the mo	de of dying,	such as c	ardiac or r	respiratory a	rrest,	INOVI		Approximate Interval Between	1
y,	Physician		Immediate Cause (Final disease or condition	, sinc sauce 511	11/0	CAR.	DIAL	- 15	che	emic	5				Conset and Death	1
1	/Medical Examiner		resulting in death)	Due to	(or as a c	onsequence of):	1	- 15 Jmf	1						17	- 1
ч	LAGIIIIICI	er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a c	ensequence of):	L	ymp	MOV	non	4				NO 11	13.
	outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c												
õ	bete be executed by sicien and the burial-transit	Exe	resulting in death) Last	Due to	(or as a c	onsequence of):										
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit	dicai	M	d												
Box 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou				2020706				2	3d. Date of	delive	ry	
	ie death the atte hed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown		nant at tim		3 □Ectopic 5 □ Other (s						Month		Day Year	
0.	The law requires thet the de sie hes been signed by the a bage 2 should be detached f	/Ph	Part II. Other significant condition	s contributing to	death but r	not resulting in the	underlying	cause given	in Part I.		23e. Did	tobacco u	se contribu	te to the	e cause of death	?
Sp	w requires been sign should be	ed by									10	Yes 2[	]No 3[	] Proba	ably 4 □Unkn	own
Records,	e law re hes bee je 2 sho	Completed									24a. Was	DSV	24b. Wer	e autop	sy findings avail	able
<u>~</u>		Com									1 Yes	2 No	deat	h? Yes	2 No	
Vita	tician: Th certificete rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	11	2 ☐ ER/Outpa		Other			Check only		- House /	di	RUGHERS	
ō	든 등등	n: To	27. Manner of Death	28a. Date	Inpatient of Injury onth, Day Y		e of	28c. Injury a Work?	4 🗆 1401		e 5 Res		/	Specify	HOME	
Ö	anding ath. or: Aft	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investiga	ation			М	1 □ Ye	s 2 🗆 N	40						
Division of Vital	or Atta	ertification:	3 Suicide 6 Could no 4 Homicide determin	186 28e. Plac build	e of Injury ding, etc. (	- At home, farm, (Specify)	street, facto	ry, office		28	If. Location ( City or To			r Rural	Route Number,	
	To the Hospitel or Attanding Ph within Z4 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C		Physician: To the xaminer: On the and ma		camination and/o										
	To the within To the	Me	29b. Signature and title of certifier			*	2	9c. License	number	11			e signed (A	_		
)			) MH.Z	ITEC	-A2	1		140	+10	4		7.	- 22	5 -	.06	
4	5		30. Name and addless of person w	no completed car	use of dea	th (Item 23a) (Ty	pe, Print)	Mnse	n r	Driv	e,F	ned	eril	21	40217	702
	Sta	ato.	31. Date filed (Month, Day, Year)	32.	Posistrar's	s Signature					( )					
	Regist		AUG 0 1	2006	Calle	UK	Charles.	2								

			State State Registrar	of Maryland /		rtment of tificate of		nd Mei		iene <sub>1g. No.</sub> 200	16 25	736
	Physici	an	1. Decedent's Name (First, Middle, Last)						Date of Deat Month	Day Yo	3. Time of	
	/Medic	al	Evelyn E. Purdy			45 Oh Tu -			uly 29	4c. County of	9:00	A M
1	Examin	er	4a. Facility Name (If not institution, give street and Manor Care Nursing Home			4b. City, Town, Towson	or Location of	Death		Baltimo		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Yea		4 Hrs. 8.	Date of Birth	Vear) 9.	Birthplace (State o	r Foreign
	Director		216-82-6070	92	Yrs.	Months Day:	s Hours		ct. II	, 1913 M	aryland	
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Lo	cation					10d. Inside Cit	ity Limits
	Mary	tor	Maryland Baltimore	Baltim	ore						1 ☐ Yes	2 🛛 No
	or 284	lrec	10e. Street and Number			10f. Zip Code				Og. Citizen of Wha	t Country?	
	ath wi	rai	1853 Loch Shiel Road			21234				USA		
	within 72 hours after death with the Maryland ene. Than "naturel", or tleme 23a or 28a-f ehow na Maroleal Examiter mant be notified a	Funeral Director	11. Marital Status 12. Was D Armed	ecedent Ever in U.S. Forces? S 2 1 No	13. V	Vas Decedent of Yes, specify Cu	Hispanic Origi Iban, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)		Americen Indian, White, etc.	
990	urs af	Ď	If Yes,	Give or Dates:	1	☐ Yes 2X N	o Specify:			Specify: W	hite	
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade complete		a. Deced	lent's Usual Occ kind of work don OO NOT use retii	upation e during most	of working		16b. Kind of Busin	ess/industry	
121	within	mpi		e (1-4or 5+)	omem		red)			Own Home		
d 2	Hygie Hygie other	e Co	17. Father's Name (First, Middle, Last)	11	Onen	arcı	18. Molher	's Name (F		Maiden Sumame)		
<u>la</u> n	Aental Aental rked tic ev	To Be	George Randle Tarbart				Lilli	an F1	orence	Hunt		
lary	2 sho		19a. Informant's Name/Relationship (Type, Print)	15	9b. Mailin	g Address (Stree	et and Number	or Rural R	oute Number	City or Town, Sta	te, Zip Code)	-
(ه	1 and 1ealth om 27 ther tr		Patricia Ramsburg/daug					Balt Date		MD 2123 20c. Location - Cit		
nor	Pages inent of hant: If Ite		1 ☐ Burial 2 X Cremation 3 ☐ Removal from	om State Chesa	tery, cren	sition (Name of natory or other pose. e Cremat	lace)			eltsvill		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "naturel; or theme 23a or 28a-1 show eny injury or other traumatic event, the Marical Examiner must be notified at ance.	1	4 □ Donation 5 □ Other (Specify)  21. Signaturite of Funeral Service Ligarisee	/ /	-					e P.O.		
ñ	Ded in the control of		Devel & Hell	No 125		_					11e, MD 2	21029
П			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do	o nol ente	er the mode of d	ying, such as c	ardiac or re	espiratory arre	est,	Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Incmia.							Day S	Jean
	/Medical Examiner		Due	to (or as a consequence	e of):	*					book	C
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence	e e 11	19				-	100015	,
	cuted nd transit	Examiner	that initiated events C.									
8760,	cate be executed physician and the burial-transit	a Ex	resulting in death) Last Due	to (or as a consequence	e of):							
687	icate physi s the t	edical	d									
Вох	h certii anding use a	M/		outcome of pregnancy re birth 2 Fetal dea	th all	Ectopic pregnan	201			23d. Date o	f delivery	
В	The law requires that the death certificate be executed see has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	egnant at time of death		Other (specify)				Month	Day Y	Year
P.O.	hat the		Part II. Other significant conditions contributing t	o death but not resulting	in the ur	nderlying cause o	uven in Part I.	-	23e, Did tot	pacco use contribu	ite to the cause of d	iealh?
Division of Vital Records,	uires Isigne	d by	Dementia						1 □ Ye	s 2000 3[	Probably 4 🗆	Jnknown
COL	law requir as been si 2 should	Completed							24a. Was a		e autopsy findings a	available
m m	The it	E O							autops perform	ned? dea	r to completion of ca th? Yes 28 No	ause of
/ita	cian: Sertific Sector,	Be	25. Was case referred to medical examiner?						check only on	θ)		
o	Attending Physician: sr death. •ctor: After this certifict by the funeral director.	5			Outpatien  Time of	, all box				ow injury occurred	Specify)	
on	nding th. : Afte	ation	1 Natural 5 Pending (A	ate of Injury 28b Month, Day Year)	Injury	W	ork? ∐Yes 2 ∐N					
Vis	I or Attendi after death, Director: A s in by the fu	Certification:	3 Suicide 6 Could not be	ace of Injury - Al home, ulding, etc. (Specify)	farm, str	eet, factory, offic	9	28f	Location (St. City or Town		or Rural Route Num	ıber,
۵	ital o irs aft ral Di lled in	Cer										
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical	29a. Certifier  (Check only one)  29a. Certifying Physician: To the control on th	the best of my knowled to basis of examination a nanner stated.	ge, death and/or inv	occurred at the restigation, in my	time, date and opinion, death	place, and occurred	I due to the ca at the time, d	ause(s) and manno ate and place, and	or as stated. due to the cause(s	;)
	ro the	Me	29b. Signature and title of certifier	2			nse number		2	9d. Date signed (A	Aonth, Day, Year)	
			I peror 1/lac	& mo	0	D00	61199			J.14,3	1,2006	
70	7		30. Name and address of person who completed of						7 -	MAN O	1204	
シ 	- CA	10	30. Name and address of person who completed of Sasan Black, 6565 and 31. Date filed (Month, Day, Year)	Vor IL Char 2. Pristrar's Signature	rks.	57,50	110 10	7 . 1	ouson	77) 2	701	
	Sta Registi		AUG 0 1 2006		1	asid )						

	-	For State Registrar	State	of Maryla				ealth a Death		ental F	lygie Reg.	211	06	25737
Physicia /Medica			e Viola		-					2. Date of Month July		<sup>Day</sup> 2006		3. Time of Death 1:32 p M
Examine Funeral	10 m	4a. Facility Name (If not institution,	give street and r	VIII30	last birthday)		r 1 Year	Location of	nsta	8. Date of	Birth	4c. County	115	
Director		217-07-1606 Usual Residence of Decedent	1□M 2ਊF	85	Yrs.	Months	Days	Hours	Min.	sep 1	2, 1	920	Cou	yland
ва-f show	ctor	Tat y teria	roll	10c. (	City, Town or Lo	ocation	W	estmi	inste	er				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ath with the 23a or 2	Funeral Director	2301 Frizzellb					p Code		158			Citizen of \	sa	
ours after de	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ※ Widowed 4 ☐ Divorced	Armed	ecedent Ever in Forces? s 2 <b>%</b> No Give Dates:		Was Dece If Yes, spi 1 Tyes		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	cify Yes or Rican, etc.)	No-	Blac	e - Americk, White,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other treumatic event, the Marylast Examinar must be notified at once.	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12) 12	t grade complete	d) (1-4or 5+)	16a. Dece (Give life.	kind of w DO NOT	ork done d	fu <i>ring m</i> os )	t of workii	ng	166	O. Kind of B	wn Ho	
Vicilia build be filed Mental Hyg srked otherstic event,	To Be C	17. Father's Name (First, Middle, L Henry J. Liebr								(First, Mio		den Suman <b>aw</b>	ne)	
end 2 sho eelth and m 27 is ma		19a. Informant's Name/Relationsh Bonnie Q. Barne			2301	Friz	zell		Road	, Wes	tmin	ty or Town. ster,	MD 2	21158
Deficiency of the properties o		20a. Method of Disposition  1 → Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		m State Lo	Place of Dispo cemetery, cre oudon P	matory or ark (	other place Cemet	ery	8/02	/2006		Location - Balti	more	, MD
permit. Depertrement imports ony injury		21. Signature of Funeral Service L	icensee	M0119								raw F er, M		al Home 157
cate be physicie the bur	dical Examiner	23a. Parh. Enter the disease, or shod, or heart failure. List of the same sale cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. List didentifying Cause (Disease or injury that initiated events resulting in death) Last	a	o (or as a conse	equence of):	Control of the contro		en h		rrespirator	y arrest.			Approximate interval Between Onset and Death
thet the death certificated by the ettending place detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	outcome of preg e birth 2 Te gnant at time of known	tal death 3	□Ectopic p □ Other (s					_		te of delive	ery Day Year
v requires that been signed to should be deta	ρ	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	inderlying	cause give	in in Part I.	·		id tobaco □ Yes	co use cont 2 No		he cause of death? pably 4 Unknown
al necon: The law relicete has be	Completed										utopsy erformed	3/ 3	prior to co death?	psy findings available mpletion of cause of 2  No
To the Hospital or Attending Physician: The law require within 24 hours after death. To tha Funeral Director: After this certificate has been significately filled in by the funeral director, page 2 should be a	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investig	28a. Dat (Mo atton	Inpatient 2 e of Injury onth, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	er: 4 Nu	rsing Hor		esidence	e 6 □Oth		y)
Othe Hospital or Attending within 24 hours after death. I the Funerel Director: Alexampletely filled in by the funerel Completely filled i	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Pla bui	ce of Injury - At Iding, etc. (Spe	cify)					City or	Town, Si	tate)		al Route Number,
the Hosp hin 24 hou tha Fune npletely fil	Aedicai	one)	Physician: To t examiner: On the and ma	he hast of my k basis of exami anner stated.	nuwledge, deal nation and/or in	vestigatio	n, in my op	oinion, dea	d place, a th occurre	and due to to ad at the tin	ne, date	and place,	and due to	the cause(s)
WIL	Σ	29b. Signature and title of certifier	Jame /	nelm	2		c. License	0599	43		29d.	Date signed	d (Month,	Day, Year)
Stat Registra	-	30. Name and address of person v	m z	Line .	nature	2	Suit	4, 3,	67 C	125)	min	nster	Nº	= 2115)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland		artment of F rtificate of				gierie Reg. No. 4	2006	25738
			1. Decedent's Name (First, Middle, Las	1)						Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		JOSEPH E. RUS	SELL						ULY 27,			11:10 P M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of	of Death			County of Death	
			FAIRLAND NURSING AND				SILVER SPI		0.11-			TGOMERY	
b	Funeral Director		577-14-1012	X 7. Ag XM 2□ F	e (In yrs. la 88	ast birthday) Yrs.	ff Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day BRUARY	, Year)	9. Birth Cou 918 MARYI	place (State or Foreign intry) AND
	and	,	Usual Residence of Decedent  10a. State 10b. County		10c. City	. Town or Lo	cation						10d, Inside City Limits
	Maryil 1 eho	5		7	CTIVE	R SPRIN	IC.						1 ☐ Yes 2 🛣 No
	28e	rect	MARYLAND MONTGOMER  10e. Street and Number	L	DILVE	A DI KI	10f. Zip Code			1	10g. Citize	en of What Cou	intry?
	3a or		9917 COTTRELL TERRACE				209	903				U.S.A.	
	deati	ner	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Ori	igin? (Specify	Yes or No-	14	4. Race - Amer	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "naturel; or Items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∑Yes 2 ☐ If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No			ari, etc.)		Black, White Specify: WH	ITE
5-0	72 ho natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	1	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation	t of working		16b. Kind	d of Business/I	ndustry
2	ithin ne.	du	Elementary/Secondary (0-12)	Coflege (1-4or 5	5+)			1)			** 0	LTD HODG	5
121	fled w tygies ther th	ပ္ပ	17. Father's Name (First, Middle, Last)			CARPEN	TER	10 Moths	er's Name (Fi			AIR FORC	<u> </u>
Maryland	ntal hed of	Be		RUSSELL				ELSIE	or a realing (F)	irst, Middle,		MPSON	
2	hould d Me mark matic	우	MARTIN  19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address (Street		er or Rural Ri	oute Number			n Code)
<u>⊠</u>	nd 2 strict		NANCY M. CANNADY/DAUG				GEBROOK ROA						
<b>.</b>	t Head the other		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of natory or other place	1	Date			ation - City or T	own, State
Baltimore,	rtment o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	)		OF HEA	VEN CEMETE	RY (	08/01/20	006	SILVER	SPRING,	MARYLAND
Ba	Deperming Deperm		· amanda	Luder	via_	HI 11		I FUNEI MPSHIRE	RAL HOME E AVENUE	E, SILVE		ING, MAR	YLAND 20904
			23a. Part1. Enter the disease, or come shock, or heart failure. List only of	fications that caused one cause on each li	the death	. Do not ent	er the mode of dyin	ig, such as	cardiac or re	spiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	a. ACUTE MYC	CARDIA	L INFAF	RCTION						
	/Medical Examiner		Tosularing in doutry	Due to (or as									
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	uted J ansit	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CORONARY			SE						
Ć	exect an and ial-tra	Еха	resulting in death) Last	Due to (or as				<del></del>					
68760,	tificate be executed ig physicien and as the burial-transit	edicai Examiner	(	d									
	rtifica ng ph s as th		IF FEMALE:										
P.O. Box	w requires that the death cert been signed by the attendin should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)				23	ld. Date of deliv Month	ery Day Year
	requires that the een signed by th nould be detache	by P	Part fl. Other significant conditions co	entributing to death b	ut not resu	Iting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ğ	en sig	ed								1 🗆 Y	es 2□	No 3 ☐ Pro	bably 4 Tunknown
Records,	sician: The law re certificete has be irector, page 2 sho	Completed	24a. Was an autopsy performed?									death?	opsy findings available ompletion of cause of
Vital	un: T lificet or, pe	ပို	25. Was case referred to medicaf					26 Place	of Death (C	1 Yes		1 🗆 Yes	2 □ No
$\leq$	Physician: this certificate rail director, i	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 E	ER/Outpatien	t 3 DOA Oth					Other (Speci	fv)
J of	ig Ph ter th neral	L:u	27. Manner of Death t ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry v Year)	28b. Time of Injury				. Describe h			
010	auth. or: Af he fu	atic	2 Accident investigation			,,		Yes 2□	No				
Division	al or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hoi c. <i>(Specify</i>	me, farm, str	eet, factory, office		28f.	Location (Si City or Town	treet and n, State)	Number or Rui	al Route Number,
	To the Hospital or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral director.	Medical (	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best iner: On the basis o and manner st	t examınatı	wledge, death ion and/or in	occurred at the time vestigation, in my o	ne, date an pinion, dea	d place, and th occurred a	due to the cat the time, d	ause(s) a late and p	nd manner as s place, and due t	stated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	7 1		1	29c. Licens	e number		2	9d. Date	signed (Month,	Day, Year)
			1 Com 1	la la	nal	1.1.	D5226	1			JULY 2	28, 2006	
	10		30. Name and address of person who o	ompleted cause of o	eath (ftem	23a) (Type,							
			ALAN R. SEGAL, M.D.,					RYLAND	20906				
	Sta Registr		ALAN R. SEGAL, M.D., 1517 HUGO GIRCLE, SILVER SPRING, MARYLAND 20906  31. Date filed (Month, Day, Year)  AUG 0.1 2006  32. Degistrar's Signature										

		•	For State Registrar	State of Ma	ryland			nt of He te of D		nd Me		giene Rog. No.	7 1111	6	257	139
			Decedent's Name (First, Middle, Last)							2.	Date of De.	ath			3. Time of D	Death
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	/Medic		4a. Facility Name (If not institution, give st				4b. City	, Town, or	Location of [	Death		4c.	County of De	eath		
	CAUTITI		Hebrew Home of Grea	ater Wash	ingto	n	Roc	kvill	.e			M	lontgor	nery	у	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. la	st birthday)		r 1 Year Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birt (Month, Da	h v. Year)	9. E	Birthpla Counti	ace (State or	Foreign
	Director		219-33-3553	M 21 F	79	Yrs.	1410111113	Juyo	110075		N 26,			ıss:		
P	> -		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Loc	cation							10	d. Inside City	Limits
aryla	eho a	2					J411011								1 Yes 2	
he N	28a-1	Director	Maryland Montgome:	ГУ	beti	nesda	10f 7	p Code				10a Cit	izen of What	Count	rv?	
with	D S			#002			1	817					ted Sta			
eath	70 23	Funeral	10250 Westlake Dri	2. Was Decedent E	ver in U.S	. 13. V			spanic Origin	n? (Specif	v Yes or No		14. Race - A			
fterd	E a	듄	1 ☐ Never Married 2 🔀 Married	Armed Forces?		lf If	Yes, sp	cify Cubar	n, Mexican, f	Puerto Rio	an, etc.)		Black, W	hite, e	itc.	
urs a	0,1	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	Yes	2 <b>∑</b> No	Specify:				Specify:	Whi	te	
2 P	ical i	Completed	15. Decedent's Educ (Specify only highest grade			16a. Deced	ent's Usi	al Occupa	tion uring most o	of working		16b. K	ind of Busine	ss/Ind	ustry	
ihin 7	e a	ple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. C	OO NOT	use retired)	bring most o	n working						
N P	er th	9		5+		Law	yer					La				
<b>2</b>	d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother's							
y ould	Men	은	Vladimir Kogan						Vera		Khochi					
2 sh	te m	li	19a. Informant's Name/Relationship (Typ										or Town, State			
and and	m 27		Ilya Reyz / Husban 20a. Method of Disposition	<u>a</u>	20h Pla	ice of Dispos			: DI.	Date			ocation - City			
5 8	= = D		1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State	Rive	metery, crem erdale	Par	other place	9)							
mit. Pages	rtmer		4 Donation 5 Other (Specify)		1	Cremat	ory		07 s of Facility		2006	Rive	erdale	, M	arylan	.d
De di	Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Exeminar mast be notified at once.		21. Signature of Funeral Service License		00056	Th	ibad	leau 1	lortua	ry S	ervice	, P.	.A.		0010	
			23a. Part I. Enter the disease, or complic		00956 the death.	Do not ente	3 Gi	st Av	ze., L	ardiac or r	i Lver espiratory a	Spr.	ing, M		Approximate	
			shock, or heart failure. List only one Immediate Cause (Final	e cause on each lin	16.			,							Interval Betwood Onset and De	
	ysician Medical		disease or condition resulting in death)		Juar		car	cer						-		
	aminer			Due to (or as a	a conseque	ence or):										
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):										
uted	d ansit	Examiner	Cause (Disease or injury that initiated events													
9xe	an an rial-tr		resulting in death) Last	Due to (or as	a conseque	ence of):										
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ith cer	tendi	Iclan/Me	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome 1 ☐ Live birth			Ectopic	oregnancy					23d. Date of Month		•	ваг
o dea	he et ned fo	SC	1 □ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of dea	ath 5□	Other (s	pecify)					WOIT		ouy (	ou.
T at the	been signed by the ettending p should be detached for use as	Phys	9 Unknown	Lib. Alas da da ada ba	at most record	tin - i - the			n in Cont I		220 Did t	obacco	use contribut	a to the	a cause of de	ath?
15. Tes ±	erigne b ed	ρ	Part II. Other significant conditions cont	Induting to death bo	1000 10501	ung in the ui	denying	cause give	ori ir raiti.		1 [7]		□ NO 3□			
v requir	hould	eted	- Jameson nat	erthion												
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	pag.	ပိ									1 Yes	2 1 No		es :	2 No	
VICAL iclen:	rector	Be	25. Was case referred to medical examiner?	ospital:				Othe			Check only					
2 g	ra di	. To	1 ☐ Yes 2 ②No  27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur		R/Outpatien 28b. Time of	_	UA	4 19015		5 ∐ Resi d. Describe	_	6 Other (S	Specify,	)	
ding	After fune	ig ig	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	Year)	Injury	м	28c. Injury Work	? ∕es 2 ⊡ No				,			
UIVISION OF	deat ctor: y the	flca	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At hor	ne, farm, str	eet, facto	ry, office		28	f. Location (	Street ar	nd Number or	Rural	Route Numb	oer,
	Dire d in b	Certification:	4 Homicide	building, etc	c. (Specify)						City or To	wn, State	e)			
pspit	hours unere ly fille		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of	of my know	rledge, death	occurre	d at the tim	e, date and	place, an	d due to the	cause(s	and manner	r as sta	ated.	
₽ H	within 24 hours after death. To the Funerel Director: After this certificete hes completely filled in by the funeral director, page 2.	ledical	one)	and manner sta		OH ANDOL M					at the time,					
1		Σ	29b. Signature and title of certifier	8/)				ec. License					ate signed (M			
	3		I tay & Wil	<u></u>	D	00-1-7		055	51.8			ノして	78,	امد	06	
			30. Name and address of person who con	mpleted cause of d	eath (Item	ZJaj (Type,	tres»	Roc	1 8	ork.	ille	Ma.	1 28,	( -	2005-2	_
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registra	ar's Signati	ше /		, 00	, , ,	-( 75	, ,		) \-~.	+ (		
,	Regist		AUG 0 1 20	06 /	0 10	GO.	ance)									

State of Maryland / Department of Health and Mental Hygiene For Stete Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Yeer **Physician** JULY 29, 2006 03:45 AM LILLIAN ROTH AKA LILLIAN GREEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death MONTGOMERY CHEVY CHASE MANOR CARE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 POLAND 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖺 F Yrs. 118-32-1999 92 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1X Yes 2 □ No Director ROCKVILLE MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "not any vinjury optiber traument." ŏ U.S.Á. 20852 1801 JEFFERSON STREET or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify. Specify 3 XWidowed 4 □ Divorced Completed 15 Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONVERTABLE SOFAS EXECUTIVE 18. Mother's Name (First, Middle, Maiden Surname)
SARAH "UNKNOWN" 17. Father's Name (First, Middle, Last) Be CHARLES SEMENFELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 859 IVORY HILL ROAD, WOODMERE, NEW YORK 11598 DR. STEVEN GREEN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MOUNT JUDAH CEMETERY 07/31/2006 RIDGEWOOD, NEW YORK 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DIABETES MELLITUS UNCONTROLLED if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit PRE-RENAL AZOTEMIA that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical POSSIBLE ASPIRATION PNEUMONIA IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2√□ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No 1 Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ₹ No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. Director: Af 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 29a. Certifier 🕰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-20274JULY 29, 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. KIRTI VOHRA 7710 BRADLEY BLVD, BETHESDA, MARYLAND 20817 31. Date filed (Month, Day, Year) Fegistrar's Signature 2006 AUG 01 Registrar

			For State Registrar	State of	Maryland / Dep	ertificate of L		lental Hygie	2000	25741
			Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physici /Medic	-	The	elma	Norfolk	Richa	ırds	July 29,	2006 Year	10:45 P M
	Examin		4a. Facility Name (If not institution,	give street and numb	ber)	4b. City, Town, or	Location of Death		4c. County of Deat	
			1475 Chesapeak			Owing			Calve	
	Funeral Director		5. Social Security Number 577–32–6460	6. Sex 7 1 ☐ M 2 ☑ F	. Age (In yrs. last birthday 79 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye June 11	9. Birt Co 1927 Mar	hplace (State or Foreign ountry) Tyland
	pu .	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation		<del></del>		10d. Inside City Limits
	Maryla febo	ō		vert	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Owings				1 ☐ Yes 2√2 No
	28a-	Director	10e. Street and Number	VCLC		10f. Zip Code		10g	. Citizen of What Co	ountry?
	3a or		1475 Chesapeak	e Beach Ro	oad	20736			USA	
	deat	Funeral	11. Marital Status		ent Ever in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
39	d within 72 hours after death with the Maryland Jene. Ir then "natural", or iteme 23a or 28e-f ehow The Medical Exaciliat must be molified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced		MNο	1 ☐ Yes 2 🂢 No	Specify:	,	Specific	nite
21215-0036	72 hou		15. Decedent' (Specify only highes			edent's Usual Occupa e kind of work done of		16	b. Kind of Business/	Industry
21	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4	life.	DO NOT use retired	)	9		
2	77 2 2 2		47 Falls de Nous - /Fines Middle 1	2	hc	memaker	40 Markada Nam	e (Firek Ministe Mar	own home	e
Maryland	o a b	Be	17. Father's Name (First, Middle, L		11.			e (First, Middle, Mai Amelia	King	
7	s 1 and 2 should b f Health and Menti item 27 is marked other traumatice	욘	Charles Wesle	-		ling Address (Street a				Zin Code)
M	and 2 s lealth an m 27 is her trau	ΠĬ	Deborah E. Erwi			Pat Lane				,
ē,	s 1 ar f Hea item othe		20a. Method of Disposition		20b. Place of Disp		i		c. Location - City or	Town, State
Ē	Pages ment of I ent: If its		1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate	ans Cemet	1	4-2006 CI	neltenham	, MD
Baltimore,	permit. Departm Importa		21. Signature of Funeral Service L	icensee		22. Name and Addres		West Harrison		,
<u> </u>	82558	: (0)	William	K. G.	ron	Rausch Fu	neral Hon	ne, P.A.,	Owings, I	MD 20736
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cal only one cause on ea	ch line.	nter the mode of dying		or respiratory arrest	•	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)		ras a consequence of):	Heurt 7	Ferthing			1 week
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a c insequence of):	. 1	San M.			1 month
	and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C.	r as a consequence of):	Mocenta	+u lien n	7		/ /redrive
8760,	ate be executed only sician and the burial-transit	dlcal E			, ,	remoma				9-10 month
687	ificate g phy: as the	edic		1						
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live bir	nt at time of death 5	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year
Ś	9 P	6	Par II. Other significant condition		_	underlying cause give	en in Part I.		4.4	the cause of death?
cor	w requir been si should	lete	Chronic obstrue	11 . 0 .	,	sease	· · · ·	24a. Was an	24b. Were au	utopsy findings available
Division of Vital Record	The law ate has b page 2 s	Completed		1,000	THE POOL OF	4 004 6		autopsy performe	d? prior to death?	completion of cause of
ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
× ×	Physician: this certific rat director,	욘	1 ☐ Yes 2 No		patient 2 ER/Outpati		4   Nuising m	me 5 X Residenc		cify)
o uc	0 0 0	on	27. Manner of Death  1 Natural 5 ☐ Pending	1	Injury 28b. Time , Day Year) Injury	Work	c?	28d. Describe how	injury occurred	
isic	Attending ir death. ector: After by the fune	lcat	2 Accident investig 3 Suicide 6 Could n	ot be 380 Blace of	of Injury - At home, larm, s		Yes 2 □ No	28l. Location (Stree	at and Number or Ri	ıral Route Number
Ď	tel or Attendir s after death. al Director: Af ed in by the fur	Certification;	4 ☐ Homicide determi	building	g, etc. (Specify)	Arcot, lactory, office	-	City or Town, S		and thouse transport
	To the Hospital or, within 24 hours after To the Funeral Direction completely filled in L	edical	29a. Certifier Certifying (Check only one)	g Phy <b>sician</b> : To the b Ex <b>aminer</b> : On the bas and manne	pest of my knowledge, deasis of examination and/or er stated.	ath occurred at the timinvestigation, in my op	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	0 84		29c. License	number	29d.	Date signed (Monta	h, Day, Year)
)			Gerald	1. Dem	en m.D.		111245	/	tugust	1, 2006
	12		30. Name and address of person of Gerchill Sterner	who completed cause	of death (Item 23a) (Type P. U. B)	o, Print)	Own	gs, Mar	yland :	20736
	Sta Regista		31. Date liled (Month, Day, Year) AUG	1 2006	gistres Signature	posts				

		1 - State Registrar	State of Mar		artment of F rtificate of			Reg. No.	006	25742
Physici /Medi	cal		eter J	• Sant			2. Date of Dea Month July	Day 29	2006	3. Time of Death  11:01 P M
Examir Funeral Director	ner	4a. Facility Name (If not institution, give single Frederick Memorial Street Security Number 081–32–2991	cial Hosp	pital In yrs. last birthday) 70 Yrs.	Frede If Under 1 Year Months Days	rick	rs. 8. Date of Birt	Fre	ederi 9. Birthol Count Puert	ck lace (State or Foreign try) CO Rico
70	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederick  10e. Street and Number		oc. City, Town or Lo	ocation			10g. Citizen o		Od. Inside City Limits  1 A Yes 2 □ No
Ify ISING Z I Z I D-UUSO should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23e or 28e-f show imatic event, the Medical Examinar must be notified at	by Funeral Director	346-B Prospect Blvd  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	1. #101  2. Was Decedent Event Armed Forces?  1. Zeyes 2 □ No If Yes, Give Year or Dates 19		21702 Was Decedent of H If Yes, specify Cub	0	(Specify Yes or No- erto Rican, etc.)		ace - America lack, White, e	etc.
Hygi nt.	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2  17. Father's Name (First, Middle, Last)	ation completed) College (1-4or 5+)	16a. Dece (Give life. But ch	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w d)		16b. Kind of	•	
y, Maryland end 2 should be ealth and Mental n 27 is marked o	ToB	Pedro Juan Santiago 19a. Informant's Name/Relationship (Typ Gilbert T. Keough/s	e, Print)	19b. Mailie 914 V		and Number or	Rodriguez Rural Route Number Phoenixy	r, City or Tow		
Baltimore, Maryla permit. Pages 1 end 2 should Department of Health and Nen Important: If Itam 27 is marke any Injury or other traumatic. Once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	smovar from State	20b. Place of Dispo cometery, crea Chesapeak	e Cremato	ory 08/		eltsvi		TD .
Physician /Medical Examiner per principle /Medical Examiner	dical Examiner	23a. Part1. Enter the disedese, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	ations that caused the cause on each line.	MO1251 B e death. Do not end // O COK consequence of):	everly L , er the mode of dyin	Heckro	iac or respiratory ar	. Clark rest,	sville	x 784  y MD 21029 Approximate Interval Between Onset and Death
that the death certificate by the attending phetached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of 1 Live birth 2 ( 4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	y			Date of deliver	ry Day Year
v requires v requires been sign should be	Completed by PI	Part II. Other significant conditions conf	ributing to death but r	not resulting in the u	nderlying cause gw	en in Part I.	1 ☐ Y	es 2 □ No an 24b	3 Proba	e cause of death?  ably 4 @Unknown  osy findings available opletion of cause of
if VICAL MEC ysician: The lav his certificate hes director, page 2	To Be Cor	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	2 ☐ ER/Outpatier	nt 3 DOA Ott		1 ☐ Yes  Peath (Check only or  Home 5 ☐ Resid	ne)	death? 1 ☐ Yes	
or Attending Pluger death.  Director: After the in by the funeral	Certification:	27. Manner of Death  1  Natural 5 Pending 2  Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Y 28a. Ptace of Injury building, etc. (	- At home, farm, str	M 1 □	y at	28d. Describe h	now injury occi	urred	Route Number,
Hospite 4 hours Funeral	edical	(Check only 2 ☐ Medical Examin one)	ician: To the best of re: On the basis of exand manner state	camination and/or in	vestigation, in my o	ppinion, death oc	curred at the time,	date and place	e, and due to	the cause(s)
To the To the complete	×	29b. Signature and title of certifier  30. Name and "ddress of person who con	MD  npleted cause of dear	th (Item 23a) (Type,	D-1-10	614-10			Y, 31,	2006
	ate rar	31. Date filed (Month, Day, Year)  AUG 0 1 20	7 - 5 Y 32. P Gistrar's	Signature	400 h	VEST	SEVEN	TH	STRO	ET

ORIGINAL

Richard Preston Shaw

### Please Type or Print in Black Indelible Ink

	<i>J</i> 1			
State of Maryland	I / Department	of Health a	and Mental	Hygiene

	F	- For State Registrar		Cert			eg. No. 2	006 2574			
Physicia		Decedent's Name (First, Middl						2. Date of Deat Month	Day Year	3. Time of Death 0910 hrs	
Medical Examir		Richard Prest 4a. Facility Name (if not institution	on Shaw	1		b. City, Town, or Lo	ocation of Death	July 26, 20	4c. County o		
		7466 New Ridge Road		,		Hanover			Anne Aru		
Funeral		5. Social Security Number	6. Sex 7. As	ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt	th(MM/DD/YYYY)	9. Birthplace (State or	
irector		214-48-1882	1 X M 2 F	56	Yrs.	Months Days	Hours Min.	04/29/	1950	Foreign Country) MT	
	Ŀ	Usual Residence of Decedent									
v any		10a. State 10b. County  MD Anne	Amundol	10c. City, T	own or Locati					10d. Inside City Limits	
land f shov	١		e Arundel			Hanover				1 Yes 2 X No	
Mary r 28a- ed at	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of Wh		
th the Maryland 23a or 28a-f show notified at once.		7510 Terrain	12. Was Deceden	t Ever in U.S.	12 \\( \( \)	21 s Decedent of Hispa	1076	oify Vac or No.	US 114 Page	- American Indian, Black.	
death wi	Funeral	11, Marital Status 1 Never Married 2 M	arried Armed Forces	?		es, specify Cuban, I			White	, etc.	
ter de		3 Widowed 4 X Div	orced If Yes, Give Year	X No	1	Yes 2 X No	specify:		Specify:	White	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	함	15. Decedent's Education (Spe	or Dates: cify only highest grade co	mpleted)		's Usual Occupatio			16b. Kind of Bus	siness/Industry	
72 hc	Completed	Elementary/Secondary (0-12)		5+)	•	ost of working life. I ner/Opera		eu)		ent Agency	
903( within lene.	힑		3	,	Ow			(P)		<u> </u>	
filed if the orth		17. Father's Name (First, Middle, John D. Shaw	, Last)			18			Maiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	e Be	19a. Informant's Name/Relations	ship (Type, Print )		19b. Mailing	Address (Street	Laura Number or Ri			n, State, Zip Code)	
MD 3 od 2 shou alth and 1 m 27 is a	-	Laura Mary Sha	aw/ Mother		4 R	iverview	Road, Se	everna :	Park, MD	21146	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition			ace of Dispos ematory or oth	tion (Name of ceme		Date		City or Town, State	
MOT Pages ent of nt: II		1 Burial 2 X Cremation 4 Donation 5 Other S		Late		rematory	Jul	Ly 28, 2006	Baltim	ore, MD	
Baltimore, permit Pages I an Department of Hee Important: If ite	1	21. Signature of Funeral Service			22 N Ba	ame and Address o	of Facility Sons P	A Sev	orna Par	k Funeral Home k, MD 21146	
<b>a</b> a a a ii	4	/ Momas	Aller	tchie H	vy, Sev	erna Par	k, MD 21146				
Physician /Medical	1	23a. Part I. Enter the disease, or failure. List only one cause	on each line.	respiratory arre	est, snock, or nea	Approximate Interval Between Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gunsh  Due to (or as a con-							Death	
and the same of th			b.	504401100 01)							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con-	sequence of)	:	···					
= ====	Examiner	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a con:	sequence of)	:						
uted		events resulting in death) Last	d					<u> </u>			
3760, ficate be executed g physician and s the burial - transi	/Medical	UNPENDED	AMENDED								
Box 68760, e death certificate be the attending physic ed for use as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes, outcome				Ectopic pregnar		23d. Date of		
r 68 certif ending use as		past 12 months?	I LIVE DILAI	at time of dea	41	tal death 3 _ ner (Specify)	ectopic pregnar	icy	Month	Day Year	
Box: death the attrict for r	Physicia	1 Yes 2 No 9 Un	known 9 Unknown								
O. nat the xd by t	by P	Part II. Other significant condi	tions contributing to dea	th but not res	sulting in the u	inderlying cause giv	ven in Part I.			bute to the cause of death?	
S, P	q pe		*							Probably 4 Unknown	
ords w requires been should	pet		<u> </u>					24a. Was autop	sy p	Vere autopsy findings available rior to completion of cause of eath?	
Division of Vital Records, P.O. and or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by the funeral director, page 2 should be detach.	Completed	1 ✓ Yes 2 No 1 ✓ Yes									
tal F cian: certifi ector,	Be	25. Was case referred to medica examiner?	Hespital			10	of Death (Check of Death (Chec				
f V; Physi er this	ျ	1 Yes 2 No 27. Manner of Death	ı III III pat		ER/Outpatient 28b. Time of I		<u> </u>		Residence 6		
n o nding h. : Afte	io.	1 Notural	28a. Date of In Month, Day FOUND:		FOUND:			Subject was			
ivision or Attend after death. Director:	icat	2 Accident Inve	estigation Jul 26, 2006		0903 hrs me, farm, stree	et, factory, office bu	ilding, etc.	28f. Location (S	Street and Numbe	er or Rural Route Number, City	
Div tal or urs after	Certification:		old not be (Specify)	-				or Town, S 7406 New R		nit 9, Hanover, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after feath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal - transit		29a. Certifier 1 Certifying P	Physician: To the best of								
To the within To the comple	Medical	one) 2 Medical Exa	aminer:On the basis of ex and manner stated		id/or investiga	tion, in my opinion,	death occurred at	the time, date	and place, and du	ue to the cause(s)	
F 3 F 0	ž	29b Signature and title of certifi	ier // //	a		29c. License				ed (Month, Day, Year)	
		ape kna se	asself M	ツ\		O.C.N	1.∟.		July 27, 200	٥ <i>ل</i>	
		30. Name and address of person				enn Street, Ba	altimore MD	21201			
		Melissa Brassell, MD					animore, IVID		•		
Regis	tate trar	JUL 3	31 Date filed (Month, Day, Year)  JUL 3 1 2006  32 Jegistrar's Signature								
DHMH 17 Rev 1/2	2001		7								

			1 - For State Registrar	State of M	Maryland		artment o			ınd M	lental F		ene 0	0.6	2574	T- made
	Physicia	20	1. Decedent's Name (First, Middle, L	ast)							2. Date of Month	Death	Day	Year	3. Time of Death	h
	/Medic		EILENE MAE	SINES							JULY			06	7:20 P.	М
	Examin	er	4a. Facility Name (If not institution, g				4b. City, To		_ocation o	f Death			4c. County			
			11501 STONEY CR			t highday)	LAVA		If Under 2	04 Hrs	8. Date of	Diah	ALL	EGAN		-/
	Funeral Director		5. Social Security Number 6.  220–34–2133  Usual Residence of Decedent	Sex 7 1 □ M 2 🛱 F	Age (In yrs. las	Yrs.		ays	Hours	Min.	(Month,	Day, 1	(ear) 1939	Cou	place (State or Fore ntry) RYLAND	ngri —
	land		10a. State 10b. County		10c. City, 1	Town or Lo	cation								10d. Inside City Lim	nits
	Mary -f eh	호	MD ALLE	GANY	LAV	ALE									1 ☐ Yes 2 <b>X</b>	No
	r 288	lrec	10e. Street and Number				10f. Zip Co	ode				10	g. Citizen of V	What Cou	ntry?	
	72 hours after death with the Maryland naturel; or Items 23a or 28a-f ehow disal Exar illier rount be ricilified at	Funeral Director	712 MILLER STRE	ET			215	502					U.S.A			
	deat	ner	11. Marital Status	12. Was Decede Armed Force		13.	Was Deceden	t of His	panic Orig	gin? (Spe	ecify Yes or	No-		e - Ameri	ican Indian,	
9	after or Ite	F	1 Never Married 2 Married	1 Tes 27			1 □ Yes 2 <b>X</b>			, 1 00110	, 110411, 010.7		Specify			
93	72 hours naturel',	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Date:	s:									WI	HITE	
21215-0036	"natur	Completed	15. Decedent's (Specify only highest g	Education rade completed)		(Give	dent's Usual C kind of work o DO NOT use i	done du	ion i <i>ring m</i> ost	of worki	ng	11	6b. Kind of B		ndustry	
12	within ene. then "	m d	Elementary/Secondary (0-12)	College (1-4d			NG DEPA		ידיואיםי	CT.ED	K		CLOTH MANUF		ਰਾਜ਼ਰ	
d 2	Hygi Ther nt,		17. Father's Name (First, Middle, Las	st)	F	HONTI	אנונו או					dle, Ma	aiden Suman		IVLIV	
Maryland	uld be i Mental i irked oi itic eve	o Be	CLARENCE WILBUR	SHOOK					EVE	LYN	JANNE	T D	AVIS			
317	d 2 should th and Men 7 is marke treumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (S	Street a	nd Numbe	r or Rura	i Route Nur	nber, (	City or Town,	State, Zi	p Code)	
	alth a 27 is		JANET MCKENZIE	/ DAUGHTE	R 1	1501	STONE	Y CF	REEK	DR.,	N.W.,	LA	VALE,	MD	21502	
ore,	of Heall Item 2		20a. Method of Disposition			e of Disponentery, crea	sition (Name natory or othe	of er place	,	Ε	ate	20	Oc. Location -	City or T	own, State	
Ē	Pages nent of i ant: if it ary or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		BIE	RTOWN	CEMET	ERY	(	7/31	1/2006	5	RAWL	INGS,	MD	
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Solvice Lic	Lachu	(LCo)	22	UPCHU 202 G	RCH	FUNE	CRAL	HOME,	P. LAN	A. VD, MD	215	502	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus y one cause on each	sed the death.	Do not ent									Approximate Interval Between	
	Pnysician	1	Immediate Cause (Final disease or condition	Med	tastat	0	Ch	ola	ne	Cai	scino	m	a		Onset and Death	l
	/Medical		resulting in death)	a	as a consequer	nce of):		-			·		and a		1	
8	Examiner		Sequentially list conditions,	b					Contra							
	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or	as a conseque	noalotje.								0.0		
_	xecut and Il-tran	хап	that initiated events resulting in death) Last	c Due to (or	as a consequer	nce of):	***									
8760,	cate be executed obysicien and the burial-transit	Ical E		`	*	,										
687	ficate p physics fis the	op .		d												
Box	leath certifica attending ph I for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			7						23d. Da	te of deliv	ery	
	death e atte d for	Icla	in the past 12 months? 1 □ Yes 2 No	4 Pregnant	i 2 □Fetal de t at time of deat		∃Ectopic preg ∃Other (spec					_	Мо	nth	Day Year	
P.0	at the de by the	Physician/Med	9 □ Unknown	9□Unknowr	1											
Vital Records, F	es tha igned be de	þ	Part II. Other significant conditions	contributing to deat	h but not resulti	ng in the u	nderlying cau:	se givei	n in Part I.				icco use cont : 2 □ No	ribute to	the cause of death?	
Ö	law requir as been si 2 should	Completed									24a. W		24b. ¹	Were aut	opsy findings availa	ble
Be	The is ate ha page 2	E O					-					rtopsy	ed?	prior to co death? 1 □ Yes	ompletion of cause 2 No	of
ital		0	25. Was case referred to medical						26. Place	of Death	(Check on			103	2 110	
<b>f</b> <	g. i≅.	To B	examiner? 1 ☐ Yes 💆 No	Hospital:	atient 2 EF	VOutpatier	nt 3 DOA	Othe	: 4 □ Nu	rsing Ho	me 5□R	esiden	ce 620th	er (Speci	y) residen	rer
n of	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury 28 Day Year)	8b. Time o Injury	f 28c	. Injury Work	at ?		28d. Descrit	e how	v injury occur	red	163KHEIN	
Sio	Attending or death.	catl	2 ☐ Accident investigat	on			М		es 2 🗆 !	No						
Division	- 0	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of	Injury - At home etc. (Specify)	e, farm, sti	reet, factory, o	office			28f. Location City or			er or Rur	al Route Number,	
	Hospital 24 hours a Funeral D		200 Cortifier 1 ACertifying	Physician: To the he	ot of my knowle		h assumed at	Ab = 4				ha	(-)			-
	To the Hospital o within 24 hours aff To the Funeral DI completely filled in	Medical	29a. Certifier 1 Certifying I (Check only 2 Medical Ex-	Physician: To the be aminer: On the basis and manner	s of examination	n and/or in	vestigation, in	my opi	nion, deal	th occurr	ario que to t ed at the tim	ne, dat	e and place,	and due !	to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Mr (In.			29c. L	icense	number			290	d. Date signe	d (Month,	Day, Year)	
	8		•	1 Jun	~~		T	>00	060	47	8	07	1201	36		
	U		30. Name and address of person wh	o completed cause of	of death (Item 2	За) (Туре,	Print) Cun			17:74		0.	1 1	0		-
	The		Afan Ahmad, M.D.	-625	Kent F	-)vo	Cun	rbe	1/21	d	MD		2150	)2		
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 3 1 21		istrar's Signatur	do do	and I									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] [ For Stete Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 615 PM **Physician** 201 ZG Janet Cecilia Souers 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, **Examiner** 105Pita altimore arylano If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 200 F 215-40-2350 Yrs. 64 Maryland **Director** Usual Residence of Decedent 10a. State 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar. Det artment of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Exercitivant by publical and 2058. Taneytown Mg Yes 2 ☐ No Maryland Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 George Street 21787 บรล Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Rubber Factory Shoe Assembly Line 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Ralph Shaffer Rachel Margaret Masonheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 George Street, Taneytown, MD 21787 Troy E. Delawder, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Lutheran 7/31/2006 Uniontown, MD 22. Name and Address of Facility 21. Signature of Funeral Servica Licensee MQ1191 Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events boloming Physician/Medical Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificete 1 Yes After this certifice funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ampatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Matural 5 Pending s after death.
I Director: After in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined To the Hospitel or Atte within 24 hours after des To the Funerel Directo completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

WJL 2

DHMH 17 Rev 1/2001

Baltimore,

Division of Vital Records, P.O. Box 68760,

Registrar

2006

30. Name and address of person who completed cause of death (Item 29a) (Type,,Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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26,

827 Linden Ave. BALTIMORE | MD

			State of Maryland / Department of Health and No. 1- State of Maryland / Department of Health and No. 12-2006 Certificate of Death	lental Hy	giene 0 0 1	5 25746
			Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physici		CARL SCIOLER Schioler	JULY	29 2006	7:45 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	0021	4c. County of De	
			SUBURBAN HOSPITAL BETHESDA		MONTGO	MERY
i	Funeral		5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Bir (Month, Da	th ay, Year) 9. E	Birthplace (State or Foreign Country)
	Director		342-40-3617 81 Yrs.		6 1925	II.
	pue ≱_		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryli F sho	ō	MD MONTGOMERY GAITHERSBURG			1  Yes 2 No
	28a-	ect	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	Se or	Funeral Director	403 CHRISTOPHER AVE. #T-3 20879		USA	
	deeth ms 2	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No	- 14. Race - A	merican Indian,
21215_0036	ie, with y latter 2 12 15 5000 s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mealth Hygiene. Item 27 is marked other than "natural; or Items 23s or 28s-f show other traumatic event, Ite Medical Examiner must be notified.	by Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puento  1 Never Married 2 Married  1 Yes 2 No  1 Yes 2 No Specify:  1 Yes or Dates:	nican, etc.)	Black, W Specify: W	
Ē	72 ho	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	dina	16b. Kind of Busine	ss/Industry
21.	- E	n ple	Elementary/Secondary (0-12) College (1-4or 5+)	9	BUILDIN	C
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2	be fill H dot	Be			, Maiden Sumame)	T A M
2	12 should be filed within h and Mental Hygiene. 7 is marked other than "Iraumatic avant, Iraumatic	၉			CE PERIO	
Melyne	d 2 st h and 7 is n traun		19a. Informant's Name/Relationship (Type, Print)  GREG NICHOLS/PERSONAL REP. 2717 JAY BIRD CT.,			
	1 and 1 and Healt ther			Date	20c. Location - City	
ozomi*leg	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  AUG  FREDERICK CREMAT.		FREDERI	
<u>a</u>	permit. Depart Import any inj		21. Signature of Fine Perus Licensee  22. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, BA		I.I.F MD	20838
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. LUNG CANCER			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
	Examiner		Sequentially list conditions b.			
	D #	lner	Sequentially list conditions, flamy, leading to min adiata cause. Enter Underlying Cause (Disease or injury			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):			
am	cate be executed physician and the burial-transit	一一	Dua to (or as a consequence or).			
an and	the gate of the state of	dlcal	d.			1
5 pc 6 145	. 0 00	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	0020	23d. Date of Month	delivery Day Year
300	that the the the the the the the the the th	4	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
1/129/06	quires t quires t no signe uld be o			10	Yes 22No 3	Probably 4 Unknown
à	hysician: The law requir his certificate hes been si I director, page 2 should I	Completed		24a. Was auto perfo 1 Yes	ormed?deatr	autopsy findings available to completion of cause of ?
CARL	ien: rtiflica	BeC	25. Was case referred to medical 26. Place of Deal			
	nysic nis ce	10 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Ho	ome 5□Resi	idence 6 Other (S	pecify)
~ 6	E E E	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day Year) Injury Work?		how injury occurred	
7	Attanding r death. ector: After by the fune	cati	2 Accident investigation M 1 Yes 2 No			
101	or Attending at or Attending safer death.	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f, Location ( City or To	(Street and Number or wn, State)	Rural Route Number,
SCHIOLER	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)	and due to the red at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
,	To th within To th	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Me	onth, Day, Year)
	`		Tuper uns D0057/2	24	7/2	9106
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Troung: BAO, MD 9715 M&C Conton DR, Rocku,  31. Date filed (Month, Day, Year)  AUG 0 2 2006  32. Egistrar's Signature	ile mi	D 2083	50
	Sta Regist	ate rar	AUG 0 2 2006  31. Date filed (Month, Day, Year)  AUG 0 2 2006  32. Begistrar's Signature			

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			1. Decedent's Name (First, Middle, La				7		2.	Date of Dea Month			3. Time of Deat	h
	Physici /Medio		Willia	m E. Smith						8	01	200	5220°	M
	Examir		4a. Facility Name (If not institution, gire	ve street and number)		,	4b. City, Town, or	Location of [	Death		4c.	County of Dea		
			Coastal Hospica	e At the	La	re	If Under 1 Year	If Under 24	YY	D-1 ( Bidb	1		mico	
	Funeral Director			Sex 7.Ao 1 [X]M 2 □ F   6	e (in yrs. 9	last birthday) Yrs.	Months Days		Min. Ma	Date of Birth (Month, Day (Ch 2	2 <sup>Year)</sup> 1	937 MD	thplace (State or Fore puntry)	эıgп
			Usual Residence of Decedent								_ , .	307 118		
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Lin	
	Be-f s	Funeral Director	MD Wicomic	0	P.	ittsvi							1 □ Yes 2 <b>√</b> □	No
	with th	Dire	10e. Street and Number				10f. Zip Code					zen of What Co	ountry?	
	sa 23g	era	7409 Gumboro Rd	12. Was Decedent	Ever in LI	C 12	218		n2 (Specifi		US	14. Race - Ame	nican Indian	
	ter d	FL	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces		1	Was Decedent of Hi If Yes, specify Cuba		Puerto Ric	an, etc.)		Black, Whi	e, etc.	
036	al', o	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🔀 No	Specify:				Specify: W	nite	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Itema 23s or 28e-f show ta Medical Examinar must be notified at	Completed by	15. Decedent's E (Specify only highest gi			16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most o	of working		16b. Ki	nd of Business	/Industry	
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2	Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Las	t)		Carpe	en ce i	18. Mother's	s Name (F	irst, Middle,			1011	
an	ld be ental kad o	To Be	Corbett Smith					Marv	Roena	Coop	er			
ary	should ind Men marka umatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a					Town, State,	Zip Code)	
	and 2 palth a n 27 is er tra		Ruby Smith				Montleau <i>i</i>		Salis	bury,	Md.	21801		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [	☐Removal from State			osition (Name of matory or other place		Date			cation - City or		
Ĕ	Pag tment tant: jury o		4 Donation 5 Other (Spec	fy)	Car		lopen Cre		-2-20			kford,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic avent, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Lice	nsee	//		2. Name and Addres						Home	
			23a. Part 1. Enter the disease of cor shock, or heart failure. List only	polications that cause	the deat	h. Do not en	108 Willia	dili St.	, Ber	spiratory arr	MQ.	21811	Approximate	
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687	certificate iding physise as the			d										
Box	ending use	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnancy				2	3d. Date of de	•	
	ed for	Physician/Med	in the past 12 months? 1 Yes 2 No	4☐Pregnant a			Other (specify)					Month	Day Year	
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	w requires that the death s been signed by the atter should be detached for u	l by	Part II. Other significent conditions	contributing to death t	out not res	aiting in the d	rideriyirig cause give	en in ranti.		124Y			robably 4 Unkno	
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ta	ilcian: The certificate rector, pag	0	25. Was case referred to medical					26 Place of	of Death (C	1 ☐ Yes 'theck only of	No Inl	1 🗌 Yes	2 No	
Ž	Physician: this certific ral director,	To B	examiner?	Hospital: 1 Hnpati	ent 2 🗆	ER/Outpatier	nt 3 DOA Othe	200				S □Other (Spe	cify)	
O L	nding Pt ath. r: After the ie funeral	Ë	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inju	iry ly Year)	28b. Time o Injury	f 28c. Injury Work	at c?	28d	. Describe h	ow injur	y occurred		
sio	tendl leath. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not					Yes 2 □ No						
Division of Vital Records,	or Atte after des Diracto in by th	ertif	4 Homicide determined	28e. Place of In building, e	jury - At no tc. <i>(Specil</i>	ome, farm, st	reet, factory, office		281.	City or Town			ural Route Number,	
	Hospital 24 hours a Funeral tely filled	aic	29a. Certifier Certifying P	hysician: To the best	of my kno	wiedge, deat	h occurred at the tim	ne, date and p	place, and	due to the c	ause(s)	and manner a	s stated.	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director.	Medical Certification:	(Check only 2 Medical Exe	miner: On the basis of and manner si	f examina	ition and/or in	vestigation, in my of	oinion, death	occurred a	at the time, d	late and	place, and due	to the cause(s)	
	To the within 2 To the comple	Σ	29b Signature and title of certifier	-/11	2,0	1	29c. License	number	75	2		e signed (Mon		
			est!	all	1/11	U	Da	162	18			5-1-0	6	
2	TE		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)	1-72	(	in	A.A	Λ 2	1802	
	Str	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ature	A SOUX	1103	Ser	(15)	100		10-	
	Regist		AUG 0 2	2008	m	N A	pade							

			1 _ State	State of Marylar		rtment of He			000	16	2571.0
			Registrar  1. Decedent's Name (First, Middle, Last)		061	inicate of D	Catri	2 Date of Dea	Reg. No. 🛴 🔰 🚶	10	3. Time of Death
	Physici							Month 7	Day 2	Year	7:50 PM
75	/Medic Examin		Joseph M. Smith  4a. Facility Name (If not institution, give st	treet and number)	,	4b. City, Town, or Lo	ocation of Death	-	4c. County o	Death	1.301
	Examin	eı	Coastal Hos	Nice at the	2 /2/10	50	ishuu		Wi	com	ico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11/08/			ace (State or Foreign
	Director		216-01-5183 <sup>1</sup> X	M 2□F 95	Yrs.	Months Days	riouis Milli.	1170873	1910	Court	MD
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or Lo	nation				10	d. Inside City Limits
	sho	7			•					10	1 ☐ Yes 🏋 🖫 No
	he M	Director	MD Worcester  10e. Street and Number	UCE	an Pin	10f. Zip Code			10g. Citizen of Wi	hat Count	
	with 1								•	iat Count	ıyı
	eath	Funeral	5 N. Pintail Drive	2. Was Decedent Ever in U	S 13 V	21811 Vas Decedent of Hisp	anic Origin? (Spe	city Yes or No-	USA 14. Race	- America	n Indian
	Iter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	II	Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)	Black	, White, e	itc.
36	urs al	by	3 Midowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2Ã No	Specify:		Specify:	White	9
Ď	within 72 hours after death with the Maryland ene. Itan "netural", or items 23a or 28a-f show he Madical Examinar nast be notified at	Completed	15. Decedent's Educ	ation	16a. Deced	ent's Usual Occupation	on		16b. Kind of Bus	iness/Ind	ustry
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P P		Be	17. Father's Name (First, Middle, Last)			11	8. Mother's Name	(First, Middle,	Maiden Sumame	)	
∑ Za		ဥ	Augustus G. Smith				Mary Pete				
a			19a. Informant's Name/Relationship (Typ			g Address (Street and			•		Code)
ວ໌	s 1 and 2 of Health of Item 27 I		Phyllis Leonardo (			Pintail Dr sition (Name of		Pines,	MD. Z18		un State
وّ	Pages nent of h int: if its		1 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cren	natory`or other place)	1			•	
Baltimore, Maryland 21215-0036	permit. Pag Department Importent: eny injury e		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License			ge Mem. Pl					•
Ba	permit. Pages Department of Important: If It any injury or 6 2006.		21. Signature of Furneral Service License	1 Rollant	. 10	Name and Address	Street Burl	bage Fu	neral Ho	me 1	
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8760	cate be executed by sicien and the burial-transit	dicai	d.								
9	0	Med	IF FEMALE:								
Вох	death certif e attending sd for use as	an/	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregn 1☐Live birth 2☐Feta	ul death 3 □	Ectopic pregnancy			23d. Date Mont		y Day Year
0	O O	Physician/Me	1 ☐ Yes 2 DNo 9 ☐ Unknown	4☐Pregnant at time of o	leath 5	Other (specify)					
<u>.</u>	that the		Part II. Other significant conditions cont	ributing to death but not res	sulting in the un	iderlying cause given	in Part I	23e. Did to	bacco use contrib	oute to the	a cause of death?
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Vis.	r Atten er deat ractor: by the	Iffic	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number	or Rural	Route Number,
ō	2.50	Certification:		Canding, etc. (Open				Only of 7011	,, olato,		
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier  (Check only 2 Medical Examin	ician: To the best of my known: or: On the basis of examination	owledge, death	occurred at the time,	, date and place, a	and due to the o	ause(s) and man	ner as sta	ited.
	- W - m		one) /	and manner stated.							
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License n			29d. Date signed	Month, D	vay, Year)
,			18			0001	53410		1/291	06	
5-	T2		30. Name and address of person who cor	npleted cause of death (Ite	n 23a) (Type, I	Print)	an ct	· SA	10 1010	210	
	Sta	te	31. Date filed (Month, Day, Year)	32. egistrar's Sign	ature	7-60000	001	OFT	13/500	7	W 1180
	Registi		31. Date filed (Month, Day, Year) AUG 0 2 200	DE Bleen.	N A	ade					up 21801

			For State Registrar	State of M	laryland		artmen			ind Me		giene	106	257	1, 0
.93	100	7	Registrar  1. Decedent's Name (First, Middle, La	ast)		061	incar	01 2	Julii	2	2. Date of De	ath	VU	3. Time of	Death
\$	Physicia		Mildred Lucille	•	er						Month July	30, 200	Year	9:40	рм
7 10	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	f Death			nty of Dea	ath	
17			Washington Cour	ty Hospit	al		На	gers	town			Was	shing		
8 ,	Funeral			Sex 7. A 1 □ M 2 対 F	ige (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birl (Month, Da	y, Year)	9. Bir	rthplace (State or country)	r Foreign
	Director		220-30-9568 Usual Residence of Decedent		-	87 Yrs.				1	March	5,1919	Boo	onsboro,	MD
	land ow	-	10a. State 10b. County		10c. City	, Town or Lo	calion							10d. fnside Cit	y Limits
	Many e-f eh	to	PA Frank1	in	Wa	ynesbo	oro							1 ☐ Yes	2XNo
	th the	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What C	Country?	
	23a (	ig	11957 Rinehart I	)rive				7268				USA			
	tems	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Deced If Yes, spec	lent of His offy Cubar	spanic Orig n, Mexican,	gin? (Speci , Puerto Ri	rfy Yes or No can, etc.)	- 14. R	lace - Am Ilack, Whi	erican Indian, ile, etc.	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates			1 Tes	2 🔀 No	Specify:			Spe	city: W	hite	
冐	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "naturel", or items 23a or 28e-f show event, the Medical Evantinar must be indiffed at	edt	15. Decedent's E	ducation		16a. Dece	deni's Usua	I Occupa	ition			16b. Kind of	Busines	s/Industry	
212	hin 72	ple	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) Coflege (1-4o	r 5+)	(Give life.	kind of wor DO NOT us	nk done d se retired)	luring most )	t of working	7				
2	filed wit Hygiene other the	Completed	10	2		Homen	naker						stic		
ם	be file	Be	17. Father's Name (First, Middle, Las	t)								Maiden Sum	ame)		
<u> </u>	2 should be and Mental is marked of reumatic ev	To	Wilbur Jones	CT Drivel		405 14-15		(011-		len F		City as Tay	Ctata	Zin Codel	
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship			1	•					er, City or Tov			i
	1 an Heat tem 2		Gerald W. Crawfo 20a. Method of Disposition	Lu/ Son	20b. P	lace of Dispo	sition (Nan	ne of	1	Da				r Town, Slate	
ē	Pages nent of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Speci		9	emetery, crer st Hav				8/2/2	2006	Hacer	e t Our	n, Maryl	bne
Baltimore,	コモモを .		21. Signature of Funeral Service Lice		i Ke							n Funer			and
ä	Depa Impo any i		Em 7/5											n, Md 21	742
2	-		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									ween			
F	Physician		Immediate Cause (Final disease or condition Cardiorespiratory Failure								Several	1			
	/Medical Examiner		resulting in dealh)	uence of):	ce of):								_		
	- Administra	70	Sequentially list conditions, if any, leading to immediate		Septicemia Several D								Days		
	ted nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury	Pancyt		·								Few Wee	kė
	te be executed ysician and e burial-transit	Exa	that initiated events resulting in death) Last		Due to (or as a consequence of):									1011 1100	100
68760,	# × 8	dical	•	Endstage Renal Disease Few Years								rs			
	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE:	23c. If yes, outcom	23c. If yes, outcome of pregnancy						23d. Date of delive		eliverv		
.O. Box	death atter	clar	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant	at time of de		∃Ectopic pr ∃ Other (sp						Month		'ear
o.	t the c by the	hys	9 Unknown	9 Unknown											
S,	signed be del	<b>by</b> Р	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	inderlying c	ause give	n in Part I.			_		lo the cause of d	
ord	w require been si should l		Hypertension								1 🗆	Yes 2 <del>∏</del> No	3 🗆 F	Probably 4 🔲	Inknown
Vital Records,	law r las be	Completed	Cardiac Arrhythmia					auto	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?			available ause of			
<u> </u>	: The	Co									1 Tes	rmed? 2 ☑ No	1 Ye	s 21 No	
Ž.	certifi rector	Be	25. Was case referred to medical examiner?	Hospitaf:				Othe			Check only				
	ding Physician: The lav h. Atter this certificate has funeral director, page 2	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 Annpatient 2 Envouipatient 3 DOA 4 Nursing Hon						tome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred					
on	Attending r death. ector: After by the fune	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigate		(Month, Day Year) Injury Work?										1
Division of	or Attendater deat Director: In by the	Hice	3 Suicide 6 Could not	a 289. Place of I	28e. Place of Injury - At home, farm, street, factory, office 28f. Location					on (Street and Number or Rural Route Number,					
ā	s afte s afte si Dir	Certification:	4 ☐ Homicide building, etc. (Specify)  City or Town,							wii, State)	n, State)				
2	To the Hospitei or Attent within 24 hours after dealt to the Funerei Director: completely filled in by the	edical	29a. Certifier 1 de Certifying P (Check only 2 Medical Exa	Physician: To the beaminer: On the basis and manner	of examina	wledge, deat tion and/or in	h occurred ivestigation	at the tim , in my or	ne, date and pinion, deat	d place, ar th occurred	nd due to the d at the time,	cause(s) and date and plac	manner a e, and du	as stated. ue to the cause(s	)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	4			290	c. License						nth, Day, Year)	
)			1 / A Pa	elle or	D			D354	497			7	. 5	1-06	
2 4	1 -2		30. Name and address of person who								1716				
	1-3		Tanvir A. Pasha	32 Bagis	etrarie Signa	Court			own, l	Md. 2	1/40				
	Sta Regist		Alic 0 2	2006	e sav	1. D.	perk	,							

	1	For State Registrar	State of Maryland	-	rtment of l			giene 2 Reg. No.	006	25751	
Physicia	ın	1. Decedent's Name (First, Middle, Last)	Swam				2. Date of Dea	Day	2006	3. Time of Death	
/Medical Examine Funeral	er %.	4a. Facility Name (If not institution, give st		-	T7 A		_	h	9. Birth	nplace (State or Foreign untry) ryland	
Director		703-07-1182   124  Usuel Residence of Decedent  10a. State   10b. County	- 00	, Town or Loc	cation		rep. 11	, 192	3 Ma	10d. Inside City Limits	
he Man 28s-feh	Director	MD Baltimore White Ha						10a. Citizer	n of What Cou	1 ☐ Yes 2 X No	
3a or	Di	20310 West Lib	erty Road		10f. Zip Code 2116	1		U.S		,	
	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: WW I	If	Vas Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)		Race - Amer Black, White pecify: W		
2 2	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I life. D	lent's Usual Occu kind of work done DO NOT use retin	a during most of war ad)	rking		of Business/I		
filled v Hygie other t		12 17. Father's Name (First, Middle, Last)		песс	cer car	<del></del>	me (First, Middle,			IIIICII C	
	To Be	Otis M. Swam				Laura	B. Wal	Lker			
Maryland 2121 d 2 should be filed within th and Mental Hygiene. 7 is marked other than " treumetic event, the Mas	1	19a. Informant's Name/Relationship (Typ				t and Number or Ru				ip Code) 1,MD 21161	
Nore, Maryls ges 1 and 2 should tt of Health and Mer if Item 27 is marks or other traumatic	1	Edith Louise Sw  20a. Method of Disposition  1 Purple 2 Cremation 3 Re	20b. Permoval from State	lace of Disposements, crem	sition (Name of natory or other pl	ted Aug	Date . 10,	20c. Local	tion - City or 1 Hall	Town, State	
Baltimore, I permit. Pages 1 and Dep riment of Healt Important: If Item 2 any njury or other	*	4 Donation 5 Other (Specify)	er en C	22		ry 20 ress of Facility J nd St.,	.J. Harte	enstei	in Mor	tuary, Inc.	
Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	eations that caused the death e cause on each line.	n. Do not ente	er the mode of dy	ring, such as cardian	c or respiratory a	rrest,		Approximate Interval Between Onset and Peath	
Medical Examiner  physicien and the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseq	HTIC uence of):	HEX	het D	ISEA	E		chnomic	
BCOTGS, P.O. BOX 08/00, second law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	by Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)							very Day Year	
dS, F.	d by Ph	Part II. Other significant conditions con	at conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc						co use contribute to the cause of death?  2 Probably 4 Unknown		
The The ate h	Completed						24a. Was auto perfo 1 Tes			topsy findings available completion of cause of	
Of VITAL Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					ath (Check only one)			
F sic	: To	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	28c. Inj	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred					
DIVISION OT al or Attending Phy s eiter death. In Director: Atter this	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		M 1 [	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
DIVISION To the Hospital or Attenwithin 24 hours eiter deati To the Funeral Director:		29a. Certifier 1 Certifying Phys	building, etc. (Specificant To the best of my known ter: On the basis of examina	wiedge, death			e, and due to the	causa(s) ar			
To the Hospital within 24 hours of To the Funeral I completely filled	Medical	29b. Signature and title of certifier	and manner stated.	1/		nse number	2		signed (Mon)		
10		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)	US TO	7	180	0+1	LUUB	
Sta	ite	31. Date filed (Month, Day, Year) 2006	M ON N	<b>1</b> (1) 5	601 (	och Ka	iven !	21//	ba	21239	

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	St	ate o	f Mary	lanc				lealth a Death		lental Hy	gien Reg. N	200	5 25	753
3	100		1. Decedent's Name (First, Midd	e, Last)									2. Date of De	eath			of Death
	Physicia /Medic	_	Earl	Joh	n			$T_{W}$	igg				Month Augusi	. 6	зу <sub>Уеа</sub> , 2006		45 A M
	Examin		4a. Facility Name (If not institutio			m <i>ber)</i>			4b. Cit	y, Town, or	Location of	of Death			. County of De		
			Devlin Manor	Health	Car	e Cer	ntei	r		Cum	berla	nd			Alleg	gany	
	Funeral		5. Social Security Number	6. Sex				ist birthday)	If Und Month	er 1 Year S Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D.	rth av. Year	0.5	Sirthplace (State Country)	e or Foreign
	Director		217-10-7634	1 🔀 M	2LJ F	10	1	Yrs.	141011111	Juys	Tiodis		01/18/	1905		yland	
Т	D > 0		Usual Residence of Decedent  10a, State 10b, County			10	c City	Town or Lo	antion							10d. Inside	City Limits
	anyla shov	_	, , ,	egany		10	c. Oity,			rland							es 2 No
	186-f	ectc		egany													
	with t	ă	10e. Street and Number						101. 2	ip Code				10g. C	itizen of What	Country?	
	e 23	Funeral Director	518 Marsha	7		edent Ever	rin II S	12.1	Mac Doc		21502		noify Voc or N		USA 14 Bace A	nerican Indian,	
	Item Item	Ä	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	A	med Fo	orces?	111 0.3	. 13.	If Yes, sp	ecify Cuba	n, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)		Black, W		
2	irs af	by F	3 ☑ Widowed 4 ☐ Divorced	11	Yes, Giv	ve **			1 🗆 Yes	2 <b>∑</b> No	Specify:				Specify:	White	
5	be ilied within 72 hours after death with the Maryland at Hygiene. Ist Hygiene. Is dother than "natural" or items 23a or 28e-f show avent, the Madical Examinar must be notified a	ted	15. Deceder	it's Educatio	n			16a. Deced	dent's Us	sual Occup	ation			16b. i	Kind of Busines	ss/Industry	
2	hin 7	Completed	(Specify only higher Elementary/Secondary (0-12)	T		1-4or 5+)		life. I	RING OF V DO NOT	use retired	during mos	t of work	ing				
7	d with	NO.	5		vollege (				Cust	odian					Public	School	S
2	othic	Be	17. Father's Name (First, Middle,	Last)							18. Mothe	er's Name	e (First, Middle	, Maide	n Sumame)		
<u> </u>	s 1 and 2 should be liled within 72 hours after death with the Marylan Health and Mental Hygiene. If Health and Mental Hygiene. It is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	To	Jairus			Twigg	g				Feb	ee			Ath	ney	
<u>a</u>	2 sho and I Is ma		19a. Informant's Name/Relations	ship (Type, F	Print)				-						or Town, State		
2	and and n 27 n 27 ner tr		John H. Balch	/ step	son							reet	, Cumbe	erla	nd, MD	21502	
ב כ	of Head fitam r othe		20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation	3 □Bemo	val from	State 2	Ob. Pla	ace of Dispo m <i>etery, cr</i> en	sition (A matory o	ame of other plac	e)		Date	20c. L	ocation - City	or Town, State	
Ĕ	Pages nent of I ant: If it ury or o		4 Donation 5 Other (5		Vai 110111		Gree	enmour	it C	emete	ry 0	8/08	/2006	Cu	mberlar	nd, MD	
	permit. Pages Department of h Important: If its any injury or of once.		21. Signature of Funeral Service	Licensee	L	<	1						ams Far		Funera	1 Home 21502	, P.A.
	*		23a. Part1. Enter the disease, o	complication	ns that c	ansed the	death.						·			Approxim	ate
	Physician		shock, or heart failure. List Immediate Cause (Final	only one ca		A	1	_		0 1	-	_				Onset an	
	/Medical		disease or condition resulting in death)	a	Due to	(or as a co	nsabu	ence of):	ial	my	eu	v				man	dut
	Examiner					Co	~~~	~ (1	The	- /	Luse	4				MAS	-
Į,	*	Jer	Sequentially list conditions, if any, leading to immediate	<b>J</b> b. —		(or as a co										1	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.														
ว์	en ar rrial-t		resulting in death) Last		Due to	(or as a co	nseque	ence of):									
000	The law requires that the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai		d													
0	ng ph as th	0	IF FEMALE:											T		1,	
200	that the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant			tcome of prointh 2			Ectopic	pregnancy					23d. Date of c		ie.
	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4		nant at time			Other (				·		Month	Day	Year
י ב	at the	Phy	9 Unknown										1				
ń	w requires that s been signed t should be det	by	Part II. Other significant conditi		iting to de	eath but no	ot resul	lting in the u	nderlying	cause give	en in Part I.				use contribute		
cords,	pinoi s uee	ted	ann	-4-									1	Yes 2	2.⊟No 3∐	Probably 4 [	_JUnknown
ב	as b	Completed											24a. Was		24b. Were prior t	autopsy finding o completion of	s available cause of
=	The page	Con											perfe 1 ☐ Yes	ormed?	death	? es 2□No	
<u> </u>	hysician: The law his certificate has b I director, page 2 sf	Be (	25. Was case referred to medical examiner?								26. Place	of Death	(Check only	one)			
=	Physi this c	ပ္	1 ☐ Yes 2 ☐ No	Hospi	1 📖 1	Inpatient		R/Outpatien	it 3□ I		4 14 140	irsing Ho	me 5 Res	idence	6 □Other (S <sub>i</sub>	oecify)	
=	ng P After t	on:	27. Manner of Death 1. ☐Natural 5 ☐ Pendi	10	Ba. Date (Mon	of fnjury th, Day Ye	ar)	28b. Time of Injury	l	28c. Injun Worl	at c?		28d. Describe	how inju	iry occurred		
VISIO	eath. lor: A the fu	cati		gation					М		Yes 2 🔲						
<u> </u>	or At fter d Direct in by	ertification:	4 Homicide determ		Be. Place buildi	of Injury - ing, etc. (S	At hon	ne, farm, str	eet, facto	ory, office		:	28f. Location ( City or To	Street a wn, Stat	nd Number or e)	Rural Route Ni	mber,
_	pitel ours a eral (	C	20a Conding 1 TV Contibut	ac Physicia	n. To the	boot of my	ı know	dodgo dosth		el es sh- s-	- 4-4	d -1					
	To the Hospitel or Attending Physician: whim 24 hours after deals at the this certificator. After this certificator has been presented in the funeral director, completely filled in by the funeral director,	edical	29a. Certifier 1 X Certifyi (Check only 2 Medical one)	Examiner:	On the b	asis of exa	minatio	on and/or in	vestigatio	on, in my o	pinion, dea	th occurr	ed at the time,	date an	s) and manner od place, and d	as stated. ue to the cause	e(s)
	To t To t	Σ	29b. Signature and title of certific	11					2	9c. License					ate signed (Mo		)
	1		8	eu						D17	565			Au	igust 7	, 2006	
	MAS		30. Name and address of person Anthony J.		ino,	Jr.,	MD	., 92	2 Na		l Hig	ghway	, LaVa	le,	MD 21	502	
100 mg	Sta Registr		31. Date filed (Month, Day, Year AUG 0 7	2006	32	Registrar's	Signatu	JI-B	رياده	,							

			1 - For State Registrar	State of Maryla		artment o			ntal Hy	giene Reg. No.	2000	2575
	Physici /Medic		1. Decedent's Name (First, Middle, Last Mildred Simpers					2	Date of De Month	Day 25	799er 7006	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	street and number)			m, or Location	of Death			County of Deat	h
	Funeral		Calvert Manor Hea 5. Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday)	Rising If Under 1 Y		24 Hrs. 8 Min.	. Date of Bi (Month, Di		ecil 9. Birt	hplace (State or Fore
, L	Director		Usual Residence of Decedent	81	Yrs.				Sept.	4, 19	24 Mar	yland
ochocM	fied at	for	Maryland Cecil		city, Town or Li kton	ocation						10d. Inside City Lim 1 ☐ Yes 2 🔼
di di	or 28e	Director	10e. Street and Number		KLON	10f. Zip Coo				10g. Citi	izen of What Co	untry?
the Color of the Manager of the Manager	The alth and Monthal Hygiene.  Health and Monthal Hygiene.  The man and monthal Hygiene.  Other treumatic event, the Medical Eraminar must be notified at	by Funeral	6 Woods Way  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		2192. Was Decedent If Yes, specify	of Hispanic Or Cuban, Mexica		fy Yes or No can, etc.)		ed Stat  14. Race - Ame Black, Whit  Specify:	rican Indian, e, etc.
2 12 13 bound	"natural	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece (Give	dent's Usual Oo kind of work do DO NOT use re	ccupation one during mos	st of working		16b. Ki	w [] ind of Business/	ite
4 L	Hyglene.	omp	Elementary/Secondary (0-12)	Cotlege (1-4or 5+) 4	Teac					Edu	cation	
3	Mental Hyg Marked otheratic event,	To Be C	17. Father's Name (First, Middle, Last)  R. Carter Simpers					er's Name ( a Mill		, Maiden	Sumame)	
200	and Mental is marked reumatic ev	_	19a. Informant's Name/Relationship (T	y, e, Print)			reet and Numb	er or Rural I	Route Numb		r Town, State, 2	Zip Code)
	D ()	H	Charles D. Tull/H 20a. Method of Disposition 1 Surial 2 Cremation 3	20b. Removal from State No	Place of Disp	ods Way osition (Name of matory or other st Metho	of	Augus	Θ	20c. Lo	ocation - City or	
	Department of Importent: If any injury or once.		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licenters)	Ce	metery 2	2. Name and A	ddress of Facil			ınera	1 Home	Maryland  1and 2190
	hysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de- one cause on each line.  END STAGE  Due to (or as a conse	RENAL	ter the mode of	dying, such as				.s.c ymar	Approximate Interval Between Onset and Death
E	xaminer	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. DI METER &	MERUT	S						
6	sician and burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. PENTON  Due to (or as a conse								
	Title raw requires that the beath beinhoade by expensed attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1   Live birth 2   Fe 4   Pregnant at time of 9   Unknown	ital death 3	⊒Ectopic pregn ⊒ Other <i>(specif</i>					23d. Date of del Month	ivery Day Year
î	n signed b	b	Part II. Other significant conditions of		esulting in the u	underlying caus	e given in Part	l.	1	_		the cause of death?
		Completed		1					24a. Was auto perfi 1 Yes	opsy ormed?	prior to death?	itopsy findings availa completion of cause 2 No
AIIGI	rthis certificate rai director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	e of Death (				
5 2	After this funeral dis	tion; To	27. Manner of Death  15 Natural 5 Pending	28a. Date of Injury (Month, Day Year)			Injury at Work?	28	5 ☐ Res d. Describe		6 □Other (Spe y occurred	cify)
DIVISION	to the notabilist or Autenturing Frigstram. within 24 hours after death. To the Funerei Director: After this certific completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, st				f. Location City or To			ural Route Number,
	vithin 24 hours after to the Funerel Dir. To the Funerel Dir. completely filled in	edicai C	29a. Certifier Certifying Ph	vsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, dea nation and/or i	th occurred at the	he time, date a my opinion, de	nd place, an ath occurred	d due to the at the time	cause(s)	and manner as place, and due	stated. to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier				cense number				te signed (Mont	,
	7		30 Name and address of the property of the pro	mpteted cause of death (It	em 23a) (Type			Durz?	Sun			
	Sta Regist	ate	31. Date filed (Month, Day, Year)  AUC 1 2006	32. Registrar's Sig		de)						

			1 - State of Maryland / Dep State of Maryland / Dep Ce	artment of Health and M rtificate of Death	fental Hygier	-2006 25755
ı	Physici /Medic		Decedent's Name (First, Middle, Last)     MARGARITA TSITRIN		2. Date of Death Month  JULY 27	3. Time of Death 7:50 P.MM
	Examir		4a. Facility Name (If not institution, give street and number)  SHADY GROVE ADVENTIST  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  ROCKVILLE  If Under 1 Year If Under 24 Hrs.		4c. County of Death  MONTGOMERY  9. Birthplace (State or Foreign
	Funeral Director		215-41-2126  Usual Residence of Decedent  10a. State  1 □ M 2	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea APRIL 15,	9. Birthplace (State or Foreign Country)  RUSSTA  10d. Inside City Limits  1 X Yes 2 \sum No
	with the Ma Se or 28s-f s	i Directo	MARYLAND MONTGOMERY ROCKVILL  10e. Street and Number  12630 VIERS MILL ROAD, APT. 616	10f. Zip Code 20853	_	Citizen of What Country?
936	i 72 hours after death with the Maryland "natural", or items 23e or 28e-f ehow alical Exacil ermant be notified at	Completed by Funeral Director		Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	- 100	ompieted	(Specify only highest grade completed) (Givilifie)  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) COUNTANT	sing	. Kind of Business/Industry
Maryland 2	wild be filed Mental Hygi arked other atic avant, I	To Be C	17. Father's Name (First, Middle, Last)  ILIA BOGOSLOVSKY	18. Mother's Name	e (First, Middle, Maid A DOVGAY	len Sumame)
Man	d 2 sho th and I 7 Is me traume			ing Address (Street and Number or Run		
Baltimore, I	permit. Pages 1 and 2 should be filed within Deperation of Health and Mental Hygiene. Importants: If Item 27 is marked other than any Injury or other traumatic event, the Monce		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of Immatory or other place) IEM. GDNS 7/31/	Date 20c.	Location - City or Town, State  LNEY, MARYLAND
Balt	permit. Depertr Import		21. Signature of Funeral Service Licensee  23a. Part. Enter the disease, or complications that caused the bath. Do not en shock or heart failure. List only one cause or each line	2. Name and Address of Facility  EDWARD SAGEL FUNERA  OO 1 ROCKVILLE PTKI	AL DIRECTI	ON, INC. LE. MARYLAND 20852
68760,	Chysician and Medical Examiner buysician and publician and street is the prival-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Immediate Cause (Final disease)  a. Due to (or as a consequence of):  HYPERSTA  Due to (or as a consequence of):	RAGIC STROK ENSION KTERY DISEA	E	Interval Between Onset and Death
P.O. Box 68	death certifi e attending d for use as	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
	sign Sign 1 be	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Division of Vital Records,	has b	Completed			24a. Was an autopsy performed 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	ysician s certifi director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatie	Other	th (Check only one) ome 5 ☐ Residence	e 6 ⊡Other (Specify)
sion of	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pa	ation: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 2 Accident 28a. Date of Injury (Month, Day Year)		28d. Describe how in	
Divis	ital or Att urs efter de ral Direct	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	,	City or Town, St	
	ts Host n 24 ho ts Fune leteły fi	dical	29a. Certifier 1	In occurred at the time, date and place, exestigation, in my opinion, death occurred	and due to the cause red at the time, date a	$\theta(s)$ and manner as stated. and place, and due to the cause(s)
	Vithir Comp	Me	29b. Signature and title of certifier  M. D.	29c. License number 0 46 36 9	29d.	Date signed (Month, Day, Year) 07-28-2006
231			30. Name and address of person who completed cause of death (Item 23a) (Type FELL) SOICO LSICY M.D. 11125	Print) RNCHVILLE PIRE	# 203	07-28-2006 ROCKVILCE M9 20852
,	Sta Regist		31. Date filed (Month, Pay, Year) 2006 32. Segistrar's Signature	carle		20852

•				State of Maryland / Department of Health and M			05757
P	mend	led item	1	1- Stete #7 & 8, 8/7/06, per F. Home Gertificate of Death E.T	, WCHD	Reg. No. 4 UUO	25756
				1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
		Physicia /Medic		Alfred Russell Taylor	7	28 2006	1432 M
4	2	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dear	h
				Atlantic General Hospital Berlin		Worceste	er
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	h 1/12/37 9. Bir v. Year	hplace (State or Foreign
		Director		214-34-5589 1× × 2 F 68 69 Yrs. Months Days Hours Min.	11/12/	1937-	MD
		pu ,		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
		ith the Marylar or 28a-f show	7				1 ☐ Yes 2 🔀 No
		he M	ecto			10g. Citizen of What Co	unta/2
		with t	급	10e. Street and Number 10f. Zip Code			ountry :
		death with the Maryland ms 23c or 28a-f show Imust to maiffed at	Funeral Director	10519 Friendship Rd. 21811  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sr	anoity Van or No.	USA - 14. Race - Ame	vican Indian
		item item	'n	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Rican, etc.)	Black, Whit	
	36	irs aff	by F	3 ☐ Widowed 4XXX Pivorced Year or Dates:		Specify:	lhite
	Ö	tura tura	ed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of won		16b. Kind of Business	Industry
	15	n n n n Aedi	Completed	life. DO NOT use retired)	king		•
	212	l with	Eo	Elementary/Secondary (0·12) College (1-4or 5+) 12 Plumber		Plumbing	
	g	Hyg othe	a	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle,	Maiden Sumame)	7,10
	an	lid be lental ked ic ev	To B	Alfred Revel Taylor Viro	inia Qu	illen	
	Maryland 21215-0036	shound N	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			Zip Code)
	Ξ	alth a		Edith Hancock (sister) 10519 Friendship Rd.,	Berlin	MD 21811	
	ē.	s 1 a of He item		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
	Ĕ	Page nent c nt: If		I Aburai 2 I Cremation 3 I removal from State	1/2006	Whaleyvill	e. MD
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23c or 28a-f show any injury or other traumetic event, the Medical Examinal must be indiffed at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	he Burb	age Funeral	Home
	ä	Departing Department of the poores.		Taraveline & Rabatte 108 William St.,			
		₹		27a. Part 1. Enter the disease, or complications that chuled the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between
4		Prysician	er.	Immediate Cause (Final			Onset and Death
1		/Medical		disease or condition resulting in death)  Due to (or as a consequence of):			
		Examiner		Premoria.			
			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
		cuted Id ransil	Examiner	that initiated events			
5	10	an ar	EX	resulting in death) Last Due to (or as a consequence of):			
	68760,	icate be executed physician and s the burial-transit	edicai	d			
	. 1			IF FEMALE:			
_	30X	ne death certific the attending p hed for use as	Physician/M	23b. Was decedent pregnant 23c. if yes, outcome or pregnancy		23d. Date of de	•
5.	2.8 B.	dea he at ed fo	sici	in the past 12 months?  1 Yes 2 No  9 Unknown		Month	Day Year
1193	% P.O.	at the I by ti	Phy	9 Unknown			
115	ds,	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_	obacco use contribute to	
11	ords,	w requii been s should	ted		101	(es 200 No 3 P	obably 4 Unknown
0	ec ec	as as	ompleted		24a. Was autop	an 24b. Were at	topsy findings available completion of cause of
20	P C	Th ate pag	Сол			rmed? death? 2 No 1 ☐ Yes	21 No
N/	ita /	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	th (Check only o	ne)	
16	-34 of V	hysic his ce I dire	0	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H		dence 6 □Other (Spe	city)
18		ding Phys	on:	27. Manner of Teath 1. Natural 5 Pending  28a. Cate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
1	3io	Attending r death. ector: After by the fune	cati	2 Accident investigation M 1 Yes 2 D No			
49	2/4 Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Ri vn, State)	ural Route Number,
Fred	Ω	oital ours al	Ce		<u> </u>		
V		To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral.	edical	29a. Certifier (Check only one) Gertifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	, and due to the or rred at the time, o	cause(s) and manner as date and place, and due	stated.  to the cause(s)
		thin 2 the othe	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mont	h. Dav. Year)
		To To		10 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		7/78/1	
				The same of the sa	1	710000	
	SI	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	chin 1	M.O 2	871
		Sta	te.	31. Date filed (Month, Day, Year)  32. Registrar's Signature		.,,	/ - (
1		Registi		AUG 0 1 2006 Keeper & April			
l							

		•	For State Registrar		State	of Marylar	-	artment <i>tificate</i>			ind Me	ental Hy	/giene Reg. No.	200	6 25757
			1. Decedent's Name	(First, Middle, La	st)							2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		LOUISE	E. TA	YLOR							July	31,	2006	16:50 p <sup>M</sup>
	Examin		4a. Facility Name (If I	not institution, giv	re street and	number)		4b. City, T	own, or	Location of	f Death			ounty of Dea	
			Harrison					Snow			14 Uso			rceste	
	Funeral		5. Social Security Nu		Sex I⊟M 2 <b>X</b> 0F	7. Age (In yrs	•	If Under 1 Months	Days	Hours 1	Min.	8. Date of B (Month, D	ay, Year)	9. Bii	rthplace (State or Foreign ountry)
	Director	-	220-09-192 Usual Residence of 0				89 Yrs.					Aprıl	6, 19	I / Ma	ryland
	/land			10b. County			ity, Town or Lo								10d. Inside City Limits
	Many	ţo	MD	Worcest	er	Gi	rdletr	ee							1 ☐ Yes 2 No
	h the	Director	10e. Street and Num	ber				10f. Zip (	Code				10g. Citize	n of What C	ountry?
	238 c	<u>a</u>	5919 Taylo	or Landi	ng Roa	d		1	329					USA	
	r dea	Funeral	11. Marital Status		Armed	ecedent Ever in ( Forces?	J.S. 13.	Was Decede f Yes, speci	ent of His	spanic Orig n, Mexican,	gin? (Spec , Puerto F	cify Yes or N Rican, etc.)	0- 14	. Race - Am Black, Whi	erican Indian, ite, etc.
9	s afte	by Fu	1 Never Marrie		If Yes,	s 2 <b>∑</b> No Give		1 □ Yes 2	No No	Specity:			s	pecity: wh	nite
9500-GLZ	within 72 hours after death with the Maryland ane. Than "natural", or Iteme 23a or 28a-f ehow ha Madical Exantiner must be notified at		<b>¾</b> Widowed 4	15. Decedent's E		r Dates:	16a Dece	dent's Usual	I Occupa	tion				of Business	
Ċ	in 72	Completed	(Specif	fy only highest gr	ade complete		(Give	kind of work DO NOT use	k done di	uring most	of workin	g			,
7 7	iane.	E	Elementary/Secon	dary (0-12)	Colleg	e (1-4or 5+)	Seams	tress					Clot	hing N	Manufacturing
	be filed within 72 hours after death with the Marylan ital Hygiane. Id other than "natural", or Iteme 23a or 28a-f show other than "natural", or Iteme 23a or 28a-f show event, the Mydical Examiner must be notified at	0	17. Father's Name (F	First, Middle, Las	')					18. Mother	r's Name	(First, Middl	e, Maiden S	umame)	
<u>a</u>	Aental rked o	To B	Sidney Wa	ard						Vici	e Da	vis			
maryland	ss 1 and 2 should to of Heelth and Ment litem 27 is marked rother traumatic		19a. Informant's Nar					-					ber, City or 1	Town, State,	Zip Code)
	and seelth m 27	1	Edward L.	<del>-</del>	(son)	1	and the same of		•	Snow		, MD 2	-		
o e	of Hi		20a. Method of Dispo 1 \$\overline{\Omega}\$ Burial 2 □	osition ]Cremation 3 [	☐Removal fro	m State	Place of Dispo cemetery, crei	natory or oti	her place			ate			r Town, State
Ē	ment ment tant: jury		4 ☐ Donation	5 Other (Speci	(y)	Spi	ringhil				3/2/2			letre	∍, MD
Baitimore,	permit. Pages. Department of h Important: if ite any injury or of		21. Signature of Full	PAD	Run		1	03 Liı	nden	Ave.	Po	me, P.	City	. MD 2	21851
			23a. Part1. Enter the shock, or heer	e disease, or con t failure. List only	plications the	at caused the dea in each line.	th. Do not ent	er the mode	of dying	g, such as	cardiac oi	respiratory	arrest,	•	Approximate Interval Between
	Pnysician	N 3	Immediate Cause (F		A	DVANCEL	ALZ	HEIM	ER'S	1	Dise	ASE			Onset and Death
	/Medical	V Y	resulting in death)	•	u	to (or as a conse									
	Examiner		Sequentially list con	ditions,	b										
	ed sit	ine	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or in	mediate tying	Due	to (or as a conse	quança or <i>j</i> .								
_	and and I-tran	Examiner	that initiated events resulting in death) Li		c	to (or as a conse	guence of):		···-					-	
3/60,	certificate be executed uding physicien and ise as the burial-transit	a E		T.			_								
/89	О Д	dicai			d										
Box	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent	pregnant		outcome of pregr		7-					23	d. Date of de	elivery
ň	death e atten	Cial	in the past 12 r	months?	4□Pr	re birth 2 Fe egnant at time of		Ectopic pre Other (spe						Month	Day Year
o.	by the destached	hys	9 ☐ Unknown		9L Ur	nknown						-			
ري ت	igned I be det	by P	Part II. Other signific	cant conditions	contributing t	o death but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco use	e contribute	to the cause of death?
ğ	v require been sig should t											1	Yes 2	Ño 3 ☐ F	Probably 4 Unknown
ပ္မ	law requires that the as been signed by th 2 should be detache	Completed										24a. Wa	s an opsy	24b. Were a	autopsy findings available completion of cause of
ř	The ate h pega	ĕ										per 1 ☐ Yes	formed?	death? 1 ☐ Ye	
Ħ	Attending Physician: The relation of the form of the forest of the fores	Be	25. Was case referre	ed to medical								(Check only			
<u>&gt;</u>	Physic this co	ဥ	1 ☐ Yes 2 🔀				☐ ER/Outpatie	_		4 E THU			sidence 6		ecify)
Ē	ding P. h. After t funera	on:	27. Manner of Death	5 Pending	(A	ate of Injury fonth, Day Year)	28b. Time of Injury		8c. Injury Work		-	8d. Describe	how injury	occurred	
200	tend death tor: /	cat	2 Accident 3 Suicide	investigati 6 ☐ Could not	ha	ann of Initial At	home form at	М		Yes 2 □ i		Of Location	(Street and	Alumbororf	Rural Route Number,
Division of Vital Records,	i Dir	Certification:	4  Homicide	determine	4 289. P	ace of Injury - At uilding, etc. <i>(Spec</i>		reet, factory	, опісе		'		own, State)	Number of F	nulai nobie Number,
	To the Hospital within 24 hours a To the Funerei Completely filled	edicai C	29a. Certifier (Check only one)	1 Certifying F 2 Medical Exa	ıminer: On th	the best of my kr e basis of examinanner stated.	nowledge, deat nation and/or in	h occurred a vestigation,	at the tim in my op	e, date an	d place, a th occurre	and due to the	e cause(s) a e, date and p	nd manner a lace, and du	as stated. ue to the cause(s)
	To the Ho within 24 I To the Fu completely	₩	29b. Signature and	title of certifier				- 1		number				-	nth, Day, Year)
	->-0			Saty	1	$M \cdot D$		. !	DOC	0621	72		7,	131/2	006
5	т 3	ų.	30. Name and address		SATYA		em 23a) (Type,		eT	57	Poco	MOKE			21851 .
		ate	31. Date filed (Mont	th Day Year)	- '	2. egistrar's Sign	•								
	, regist						- 7								

			1 - For State Registrar	State of Ma		d / Depa		Health and	Mental Hyg	•	6 25758
			Decedent's Name (First, Middle, L.						2. Date of Dea		3. Time of Death
	Physicia /Medic		Barba	ra Xenakis	Ven	eris			July 26	5, <sup>Day</sup> 2006 Year	10:03A M
ji.	Examin		4a. Facility Name (If not institution, gi	ve street and number)				or Location of Deat	th	4c. County of Dea	
			Alfred House				Rockvill			Montgome	
	Funeral Director		5. Social Security Number 6. 235–38–2794  Usual Residence of Decedent	Sex 7. Age 1□M 2 1 78		last birthday) Yrs.	Months Days			1927 Wes	rthplace (State or Foreign Sountry) St Virginia
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. fnside City Limits
	Many i-feh	Ö	Maryland Montgom	ery	Bet	hesda					1 ☐ Yes 2 🔀 No
	r 28g	Director	10e. Street and Number				10f, Zip Code		1	l0g. Citizen of What C	country?
	th will	a	5103 Dudley Lane	#302			20	0814		USA	
	r dea	neur	11. Marital Status	12. Was Decedent E Armed Forces?	er in U	.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	Ž.	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N	lo	ľ	1 ☐ Yes 2 <b>X</b> No			Specify: W	nite
8	hour	pa p	15. Decedent's 8	Year or Dates:		16a Dece	dent's Usual Occu	nation		16b. Kind of Business	s/Industry
5	n na	Completed by Funeral	(Specify only highest g	rade completed)	. \	(Give	kind of work done DO NOT use retire	ipation a during most of wo ad)	nking		amadany
212	d with	Eo	Elementary/Secondary (0-12)	5+ College (1-4or 5	+)	Socia	ıl Servic	es		Federal Go	overnment
פ	al Hyg	Bec	17. Father's Name (First, Middle, Las	.t)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>a</u>	Menta Menta arked	To	Stanley Steve X	enakis				Theodora	a Cardi	ges	
Jan	2 sho and ls m		19a. Informant's Name/Relationship			1	•			r, City or Town, State,	Zip Code)
<u>≥</u>	and lealth im 27 her ti		Nick Stevens/Nep	hew	20h B				The state of the s	,MD.20814	- T C
Baltimore, Maryland 21215-0036	in it of the		20a. Method of Disposition 1		Mox	emetery, crei	sition (Name of matory or other pla	s Cem. 7/		20c. Location - City o Cheltenham ,	
	rt. Partrant		4 □ Donation 5 □ Other (Spec 21. Signature → uneral Service Lice	1	riai					as Funeral	
Ba Ba	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-f show eny injury or other traumatic event, in Madical Examinal must be notified at once.		21. Signature Tuneral Service Lice	ala b						lgewater,Mo	
			23a. Fart1. Enter the disease, or con shock, or heart failure. List only	nplications (hat caused y one cause on each lin	the deatl ie.	h. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
*	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lung C	Cance	er					1 year
	/Medical Examiner		resulting in dealtr)	Due to (or as a	a conseq	uence of):					
E	*	-	Sequentially list conditions,	b. Due to for as a	e conse	uence of					
	rted nsit	Examiner	Sequentially list conditions, large Leeding to immediate cause. Enter Underlying Cause (Disease or injury								
	ate be executed hysician and he burial-transit	Exal	that initiated events resulting in death) Last	c. Due to (or as a	a conseq	uence of):					
68760,	e be /sicia e buri	call		d							
68	tificat ig phy as th										
Вох	The law requires that the death certifical tile has been signed by the attending phy age 2 should be detached for use as the	ompleted by Physician/Med	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnanc	ev		23d. Date of de	
	e deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at 9☐ Unknown			Other (specify)			Month	Day Year
0.0	at the	Phy	9 Unknown						an Division		
	signed d	þ	Part II. Other significant conditions  Anemia due to H					iven in Part I.		bacco use contribute t es 2□No 3□P	5/
Ö	w requir been si should	eted	Allemia dde co ii	emopeysis d	iue t	.O Iung	, cancer				TODADIY 4 EJOHKHOWN
Sec.	e law has b	du							24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of
ᇤ		O,		_					1 Yes	med/? death? 2.☑ No 1 ☐ Ye	s 2 No
Ž		Be	25. Was case referred to medical examiner?	Hospital:		50.0	0:	hor	ath Check only on	-	
Division of Vital Records,	Attending Physician: r death. sctor: After this certific by the funeral director,	2	1 Yes 2 No	28a. Date of Injur	v	ER/Outpatier 28b. Time o	II 3 DOA	4 Nursing		ence 6 Other (Specow injury occurred	ecify)
o	nding Ih. : Afte fune	tlor	1 Natural 5 Pending 2 Accident investigate	(Month, Day	(Year)	Injury	f 28c. fnju Wo	ork? ]Yes 2∐No		,,	
/isi	Atter r dea octor by the	flca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inju	ıry - At ho	ome, farm, sti	eet, factory, office			treet and Number or F	Rural Route Number,
ă	after a after a line	Certification:	4 ☐ Homicide determine	building, etc	. (Specify	y)			City or Town	n, State)	
	To the Hospital or Attending Phys within 2 hours atter death. To the Funeral Director: After this completely illed in by the funeral di	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	omple	Me	29b. Signature and title of certifier	/ /			29c. Licen	ise number	2	9d. Date signed (Mon	th, Day, Year)
)	- s - 0		> pliner	Mawless	1		D254	10		7/27/06	
			30. Name and address of person who	completed cause of de	eath (ften	n 23a) (Type.				1/2//00	
			Oliver Lawless,					Suite 20	02 01ney,	Md. 20832	2
g.	Sta		31 Date filed (Month Day Year)	2006 Registra			and)				
	Registr	ar	ANT 9 T C	.000		47					

			State		irtment of Health and M tificate of Death	lental Hygie Reg.	211116	25759
			Registrar  1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia /Medic			М.	Vines	July	30 2006	9:45 am
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	1
			Southern Maryland Hosp		Clinton If Under 1 Year If Under 24 Hrs.		Prince G	eorges
	Funeral		1 □ M 2 🛣 F	(In yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, You 9-23-1	9. Binn Cou	place (State or Foreign intry) bama
	Director	-	417-30-4514 8 Usual Residence of Decedent	<u>2</u>		7-23-1	JZJ   HIG	
	how		10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits  ty☐ Yes 2☐ No
	Be-f	Directo	Maryland Prince George	Brandyw		11.		
	with th		10e. Street and Number		10f. Zip Code	109	Citizen of What Cou	untry ?
	death with the Maryland ms 23a or 28e-f ehow r must be notified at	Funerai	13111 Brandywine Road  11. Marital Status 12. Was Decedent B	ver in U.S. 13. V	20613 Was Decedent of Hispanic Origin? (Sp 1 Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Amer	
30	be filed within 72 hours after death with the Marylan at Hygiene. Hygiene the work of other than "natural; or Items 23s or 28e-1 show event, the Musical Examinar must be notified at	by Fun	1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	0	f Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 <b>[X</b> No <i>Specify:</i>	Rican, etc.)	Black, White	
315-0036	2 hou		15. Decedent's Education	16a. Decec	dent's Usual Occupation kind of work done during most of work	ing 16	b. Kind of Business/I	ndustry
2 2	thin 7	nple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-	life. [	DO NOT use retired)			
7	ygien ygien rth t, the	Completed	12		Presser		ry Clean	ers
/land	ild be fit lental H ked oth ic even	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma.	den Sumame)	
$\tilde{\leq}$	should be nd Menta marked imatic ev	ဥ	Unknown  19a. Informant's Name/Relationship (Type, Print)	19b Mailir	Unkr ng Address (Street and Number or Rur		ity or Town, State, Z	ip Code)
Mar	th an than traus		Wanda Whittington/Niec		Brandywine Ro			20613
ē,	s 1 ar if Hea Item other		20a. Method of Disposition	20b. Place of Dispo-			c. Location - City or 1	Town, State
Ē	Page nent o unt: If ury or		1   Burial 2 □ Cremation 3 □ Removal from State  Uponation 5 □ Other (Specify)	1	as Ch. Cem 8/05	/2006 B	aden,Mar	yland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 Is marked eny Injury or other traumatic evonce.		21. Signature of Fune of Service Licensee	22	2. Name and Address of Facility 206	05 Aqua	sco Road	
D —	70 E 9 9		- Luyl		dams Funeral Ho			
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that cau ed shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	Souter C	Trough Carrier Comments			Approximate Interval Between Onset and Death
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	icate be executed physician and s the burial-transit	Examin	Cause (Disease or injury that initiated events c					
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8760	cate b physic the b	dicai	d					
9 ×	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy			23d. Date of deli	verv
Box	d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at		Ectopic pregnancy Other (specify)		Month	Day Year
о. О	t the c by the tacher	hys	9 ☐ Unknown			-		
Records, F	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	ρ	Part II. Other significant conditions contributing to death but	it not resulting in the ui	nderlying cause given in Part I.		2 No 3 Pro	the cause of death?
ပ္က	aw require is been si 2 should t	Completed	Ά.			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
		E O				performe	d/? death? No 1 ☐ Yes	
Vital	ician: Th certificate rector, pag	Be (	25. Was case refer ed to medical examiner?	/	1 -	h (Check only one)		
	ding Physician:  After this certification funeral director.	2	1 Pes 20 No Hospital: 1 Inpatie			ome 5 Residence	e 6 ☐Other (Special	city)
u G	After fune	tion	27. Manner of Death  1 □ Natural 5 □ Pending (Month, Day  2 □ Accident investigation	Year) Injury	f 28c. Injury at Work?  M 1 Yes 2 No	ZOG. DESCRIDE NOW	injury occurred	
Division of	l or Attending after death. Director: After I in by the fune	Certification:	2 Could not be	ury - At home, farm, str c. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
_	Hospital A hours Funerel ely filled	edical Co	29a. Certifier (Check only one)   Certifying Physician: To the basis of and manner sta	examination and/or in				
	To the I within 2. To the I complet	Med	29b. Signayure and title of certifier	1 301	29c. License number	290	. Date signed (Month	n, Day, Year)
	~ > F 0		DIA MASICA	Helevelle	P 7-2455	>	07,30	06
			30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Print)			The state of the s
r	1P		Laxmi Berwa 7	700 Old	Branch Ave.	, Suiteli	J. Clinto	n, MD 20735
П	Sta Regist			ar's Signature	Societies			

06-05799

### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Vivian Lloyd Vernon 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 5, 2006 1639 hrs Medical Examiner LLOYD VIVIAN VERNON 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death University Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. 8 irthplace (State or 7. Age (In yrs. last birthday **Funeral** Foreign Delaware Days Hours Months Director Mar 11 1916 222-05-1986 90 M 2X F Yrs Usual Residence of Decedent 10d Inside City Limits 10c City, Town or Location 'n 10a State Kennedvville Kent 1 Yes 2 XNo MD 28a-f show irector s 23a or 28a-10e. Street and Number 10f. Zip Code 10g Citizen of What Country ā 21645 28470 Lambs Meadow Rd. U.S.A. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, 8lack must be Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married 2 Married Yes White If Yes, Give Year 1 Yes 2 X No specify Specify: Widowed 4 X Divorced 2 or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry and 2 should be filed within 72 hours Health and Mental Hygiene Item 27 is marked other than "natur traumatic event, the Medical Exami Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 Dress Buyer Retail Dress Store 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Raymond Lloyd, Sr. Margaret Bratton 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Ccde) 21645Raymond Lloyd, Jr. (brother) 13521 Kentmore Park Rd. Kennedyville MD of Health 2 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 nt: If it crematory or other place) Cremation 3 1 X Burial 2 Removal from State Shrewsbury Cemetery Important: injury or oth 8/10/05 Kennedyville, MD Donation Other Specify lure of Funeral Service 22. Name and Address of Facility Galena Funeral L. Schaech 21635 Home of Stephen M00510 118 West Cross Galena, MD. St. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): Examine (Discess or Injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c, If yes, outcome of pregnancy 23d Date of delivery phy the b 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. e Hospital or Attending Physician: The law requires that the 24 hours after death. Fromeral Director: After this certificate has been signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other<sub>4</sub> DOA Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury 28d Describe how injury occurred 28b. Time of Injury 28c Injury at Work? 27. Manner of Death Certification: Aug 5, 2006 Driver auto auto collision 1544 hrs Natural 5 Yes 2 V No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State)
Route 298 & Blacks Station Rd , Kennedyville, M determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ca (Check only 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E August 6, 2006 Ulliville: 30. Name and address of person who completed cause of death (Item 23a) 10 Assistant Medical Examiner Margarita Korell MD. 111 Penn Street, Baltimore, MD 21201 Day, 31. Date filed (Mog State

Registrar

2006

AUG

			1 - State Amend #23P:	State of M ii&25 Per	larylan ME G8	d d Depa 58 Cer	utmen 5706 tificate	t of H	ealth a	and M	ental H	ygiene	006	2576	
П			1. Decedent's Name (First, Middle, L.								2. Date of D	eath		3. Time of Death	_
	Physicia /Medic		JOHN L. WILSON,	JR.							Month July	3. 20	Year 06	2042p	M
	Examin		4a. Facility Name (If not institution, gi	ve street and number	)				Location of			4c. C	ounty of De	ath	
			Holy Cross Hosp	ital			Silv	er S	pring	5		Mo	ntgome	ery	
	Funeral Director			Sex 7. A 1 [X] M 2 □ F		ast birthday) 7 Yrs.	If Under Months	1 Year Days	If Under : Hours	Min.	8. Date of E (Month, I) Oct. 2	Sirth Day, Year)	9. B	inthplace (State or Foreign Country) shington, DC	<i>n</i>
	<b>P</b> .		Usual Residence of Decedent												
	arytar show	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits 1 X Yes 2 ☐ No	
	e Ma	cto	MD P.G.											IM Tes 2 No	5
	be filed within 72 hours after death with the Maryland als Hygiene.  Is Hygiene do do do do do do do do do do do do do	ai Director	10e. Street and Number 6112 - 62nd Ave	nue			10f. Zip	Code 0787				10g. Citize	en of What C	Country?	
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.	S. 13. \	Vas Deced	lent of His	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)	No- 14	Race - Am Black, Wh	erican Indian,	
õ	or its	F	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 🕅	No		1 ☐ Yes :		Specify:		110411, 010.7			Black	
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פ	0 = 0 %	Be	17. Father's Name (First, Middle, Las	•								le, Maiden S	итате)		
<u>×</u>	should be and Mental   s marked o	ဥ	John L. Wilson,	Sr.					Bern	ice I	Marsha	11			
Σ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic once.		19a. Informant's Name/Relationship Shelia M. Wilson				-					ber, City or . .e, MD	Town, State, 2078		
ē,	Hea Hea tem other		20a. Method of Disposition	ne of	.	D	ate	20c. Loca	ation - City o	r Town, State					
2	Pages nent of int: If it iry or o	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery) 20c. Place of Disposition (Name of cemetery) 20c. Place of Disposition (Name of cemetery) 20c. Place of Disposition (Name of cem										2006 S	uitla	nd. MD	
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			shock, or heart failure. List only	y one cause on each	line.	Do not one	or the mod	o or aying	g, 000m 00	Jana 0	1 /	1001,		Approximate Interval Between Onset and Death	
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9	Attending Physician: The law requires that the death certificate be executed refeath. refeath. ector: After this certificate has been signed by the attending physician and better this remained by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE:												
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	edea he at	sici	in the past 12 months?	4□Pregnant a 9□Unknown	at time of de	eath 5□	Other (sp	ecify)					Month	Day Year	Ì
0.0	ires that the de signed by the a t be detached t	۲۲	9 □Unknown		_										
– Ś	gned be de	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying c	ause give	in in Part I.	•	23e. Dio	tobacco use	e contribute	to the cause of death?	
ב	w require been sic should b		370 Contra 18	word or	suse	- Por					1	]Yes 2□	No 3□F	Probably 4 X Unknown	n
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ŭ	The I te ha	E									per	opsy formed? 2)( No	death?	completion of cause of s 2 No	
<u>a</u>	an: tifica tor, p	a)	25. Was case referred to medical						26. Place	of Death	(Check only			3 2 110	
Division of Vital Records,	hysician: The law his certificate has b I director, page 2 s	To B	examiner?	Hospital: 1 ☐ Inpat	tient 2 🗆	ER/Outpatien	t 3□ DC	A Othe				sidence 6	□Other (Sn	ecifu)	
Ö	Phys or this oral di		27. Manner of Death	28a. Date of Inj (Month, D		28b. Time of	_	8c. Injury Work	at			a how injury		<del>o</del> cny)	-
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á	after Olre	Certification;	4  Homicide determine	building, e	etc. (Specify	<i>'</i> )					City or T	own, State)			
	Hospital 4 hours a Funeral tely filled		29a. Certifier 1 Certifying F	Physicien: To the bes	t of my kno	wledge, death	occurred	at the tim	e, date an	d place, a	nd due to th	e cause(s) a	nd manner a	as stated	
	24 h 24 h Fur etely	edical	(Check only 2 Medicel Exa	aminer: On the basis and manner s	of examinat	tion and/or in	vestigation	in my op	inion, dea	th occurre	d at the time	e, date and p	lace, and du	ie to the cause(s)	
	To the Hospital or Attenyithin 24 hours after deatly the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Mor	oth, Dey, Year)	$\neg$
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	(1)		30. Name and address of person who	777	CTV	MSICIO	W			÷ C1.		-	,		
(	6/				death (Item	1 23a) (Type,					en koa MD 20				
			KHANH NGUYEN, ADD  31. Date filed (Month, Day, Year)	5. 0.	trar's Signa	ture /		TACI	- obr	T118 9	*IU ZU	701			_
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			HUG I S EGO	But Marie	-	4									-

			For State	State of Maryla		artment of H <i>rtificate of L</i>			20	06	25762
			Registrar  1. Decedent's Name (First, Middle, La	st)		timodic or i	Journ	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia					Wilso	n	Month	Day	Year	12:45 A M
	/Medic Examin		Helen  4a. Fecility Name (If not institution, giv	Louis	e		Location of Death	August	7	y of Death	12:45 A
	Examin	er	915 Harding				_			llega	20.37
	Funeral		5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year	rland If Under 24 Hrs.	8. Date of Birth (Month, Day			place (State or Foreign ntry)
H	Director		217-28-0566	□M 2√F 77	Yrs.	Months Days	Hours Min.	0.1/03			mry) ISVLVania
	P .		Usual Residence of Decedent								
	unylar show	_	10a. State 10b. County		City, Town or Lo					1	10d. Inside City Limits
	Ba-f	cto	MD Alle	gany		Cumberla	ind	.,			1½ Yes 2 No
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
	ath v	- E	915 Harding Av				21502		USA		
	er de Itsm	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spanic origin) n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ha	ce - Americ ck, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2🌠 No	Specify:		Speci	ty: T	White
2-003	within 72 hours after death with the Maryland ene. than "naturs!; or items 23e or 28e-f show he Madical Examinat mout be notified at	ed	15. Decedent's E		16a, Dece	dent's Usual Occupa	ation		16b. Kind of E		
	n "ne	Completed	(Specify only highest gra	de completed)	(Give	kind of work done of DO NOT use retired	furing most of work )	ing			,
1212	i with	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemake	er		Home		
ğ	il Hygie other	Bec	17. Father's Name (First, Middle, Last,				18. Mother's Name	e (First, Middle,			
<u>ā</u>	uld be Jental rked c	ToE	Harry E	rnest	Adams		Nora	]	Evelyn	Wa	alters
Maryland 21	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturs!, or items 23a or 28a-1 show sumatic event, the Madical Examinat must be notified at	•	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Numbe	r, City or Town	, State, Zip	Code)
	and 2 ealth n 27 i		Barbara Bennett /	daughter	14615	Redwood			own, MI	215	502
S C	of H		20a. Method of Disposition  1 X Burial 2 Cremation 3	20b	. Place of Dispo	sition (Name of matory or other place	9)	Date	20c. Location	- City or To	own, State
Ĕ	permit. Peges Depertment of Importent: If it any injury or o		4 Donation 5 Other (Specif	Inemoval nom State		morial Pa	!	12006	Cumber	cland	Maryland
Baltimore,	portr portr y in		21. Signatury of Fureral Service Licer		22	2. Name and Address	s of Facility Ad	ams Fam:	ily Fun	eral	Home, P.A.
<b>10</b>	89889		Lidet Cle	lloane		104 Decati					21502
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metesta	6C	Cholous	10 (9	Janm	a		anset and Death Mink Cy o-we Cyllum
п	/Medical		resulting in death)	Due to (or as a cons	equence ol):	Cholous	1				
1	Examiner		Sequentially list conditions.	b. Meuro	00.00	Corne	tum	100,			Mun
	# #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):						
	and trans	Gm	that initiated events resulting in death) Last	C							
Š.	cien cien ourial			Due to (or as a cons	equence or).						
28760	ficate be executed physicien and st the burial-transit	edical	•	d							
_	eath certifi attending I for use as		IF FEMALE:	23c. If yes, outcome of pred	nancy				224 0	ate of delive	
XOA	death certi e attending ed for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)				onth	Day Year
o.	0 00	ysi	1 ☐ Yes 2 反 No 9 ☐ Unknown	9□ Unknown		3 0 11101 (0,00011)/					
٦.	The law requires that the tee has been signed by thi sage 2 should be detache	a A	Part II. Other significent conditions of	ontributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
ĠS.	puires	d by						1 🗆 Y	es 2□No	3 Prot	oably 41/20Unknown
ខ្ល	w requir been si should	Completed						24a. Was a	an 24b	Were auto	ppsy lindings available
Ř	: The law cate has page 2 s	Ĕ						autop	med?	prior to co death?	impletion of cause of
<u>r</u>		ပိ	25. Was case referred to medical				DC Place of Death	1 Yes		1 🗆 Yes	2 □ No
5	ysicien: is certific director,	TO B	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Ho			har /Caaad	60
Division of Vital Records,	Attending Physicism: r death. sctor: After this certific by the funeral director,		27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe h			<i>y</i> /
<u></u>	nding ath. r: Aft	atio	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury		res 2 □No				
NS NS	I or Attendi after death. Director: A I in by the fu	€.	3 Suicide 6 Could not b	e 28e. Place of Injury - Al building, etc. (Spe	t home, larm, str	eet, factory, office				ber or Rura	al Route Number,
ā	s afte	Certification;	4   Homicos	building, etc. (Spe	шу,			City or Tow	n, Slale)		
	To the Hospital or At within 24 hours after of To the Funersi Direct completely filled in by	edicai	29a. Certifier 1 Certifying Pt	ysician: To the best of my k	nowledge, deati	h occurred at the tim	e, date and place,	and due to the o	ause(s) and m	anner as s	tated.
	the H in 24 the F aplete		one)	and manner stated.							
	5 × 5 0	Σ	29b. Signature and title of certifier	Jan Jan		29c. License	number		29d. Date sign	ed (Month,	Day, Year)
	1		- Company			D0060	0478		Augus	st 1,	2006
	nes		30. Name and address of person who				711mb 01s 7	d MD	21502		
	Sta	te		ad, M.D., 62 Registrar's Sig	nature _	Avenue, (	Jumperian	u, MD	21502		
	Registr		31. Date filed (Month, Day, Year) AUG 0 2 201	Registrar's Sig	& for	role					

		1 - State Registrar	State of	Marylan		artment tificate				-	giene Reg. No. 2	006	2576
Physicia /Medic	al	1. Decedent's Name (First, Midd	WARK			4. 0:			15 1	2. Date of De Month	Day 22	Year 200 G	
Examin	ü	4a. Facility Name (If not institution WASHINGTON ADV 5. Social Security Number	MENTIST HOS		ast hirthday	4b. City,	TAK	OMA P	PARK	8. Date of Bir			OMERY
Funeral Director		5. Social Security Number 080-22-3213  Usual Residence of Decedent	1 □ M 2 <b>X</b> F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da JUNE 8	, 1924	N. S. O. I.	nplace (State or Foreig Intry) IEW YORK
28e-f ehow	ector		ONTGOMERY	10c. City	, Town or Lo			VER S	SPRIN	G			10d. Inside City Limits 1 ☐ Yes 2X No
23a or 2	al Dir	10e. Street and Number 1316 FENWICK I	LANE			10f. Zip		20910	)		10g. Citizer	of What Cou	ontry?
	by Funeral Director	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Give	es? No		Was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe n, Puerto	city Yes or No Rican, etc.)	- 1	Race - Amer Black, White Decify:	
iene. r then "natur ine Madical	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12) 12	nt's Education est grade completed)  College (1-4	or 5+)	16a. Deced (Give life. L	kind of wor OO NOT us	k done a	luring mosi )	t of workii	ng	16b. Kind	of Business/I	ndustry HOME
and Mental Hygiene. Is marked other then sumatic event, the Me	To Be C	17. Father's Name (First, Middle ARTHUR BAVE	, Last)							(First, Middle	, Maiden Su		
Department of Health and Importent: If Item 27 is main poly injury or other traum and pice.		19a. Informant's Name/Relation  FREDERICK J. V  20a. Method of Disposition  1 Å Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other ()  21. Signa ure of Funeral Search	VARK, HUSBAN 3 □Removal from St. Specify)	20b. Pl	1316 lace of Dispo emetery, cren HAVEN	FENW sition (Name natory or ot N CEMI . Name and	ICK in e of their place ETER d Addres	LANE, Y 7	APT 7/27/	. 616, ate 2006	SILVE 20c. Locat HAGER	R SPRI	NG MD 20 Fown, State
nysician Medical xaminer	icai Examiner	23a. Part1. Enter the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to minorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sloce to for the large to for the lar	as a conseque	Do not enter	BAST I er the mode Blue				BOONS BO	_	IARYLAN	Approximate Interval Between Onset and Death
S	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ☐ Fetal It at time of de	death 3	Ectopic pre					23d	. Date of dela Month	very Day Year
in signed by	2	Part II. Other significant conditi		th but not resu		iderlying ca	luse give	n in Part I.			obacco use Yes 2□N		the cause of death?
page 2 should	Completed									24a. Was auto perfo	psy prmed?	prior to o death?	copsy findings available completion of cause of
ih. Atter this certifica funeral director, p	0	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pendii	Hospital: 1 Inp		ER/Outpatient 28b. Time of Injury		Bc. Injury Work	r: 4 □ Nui	rsing Hon	Check only one 5 Residence	dence 6		ify)
s after death.	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At hor , etc. (Specify)	me, farm, stre					8f. Location ( City or To		umber or Ru	ral Route Number,
		29a. Certifier 1 Certifyin (Check only one)	ng Physicien: To the be Exeminer: On the basi and manner	s or examinati	vledge, death ion and/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, a	nd due to the od at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
To the comp	Σ	29b. Signature and title of certific	he lies	4.0		29c.	License	number GSFC	03			igned (Month	•
		30. Name and address of person	ubo complete to										

		•	For State of Maryland / Departm	nent of Health and M cate of Death		ene2 () () 6 g. No.	25764
	Physicia		1. Decedent's Name (First, Middle, Last) Floreura Bessick		2. Date of Death Month AUG	Day Year 14 2006	3. Time of Death 7. 35 PM
	/Medic Examin			City, Town, or Location of Death  BALTIMORE	710	4c. County of Death	lA
,	Funeral Director			Inder 1 Year If Under 24 Hrs.  This Days Hours Min.	8. Date of Birth (Month, Day, May 8,	1937 nort	lace (State or Foreign try)  h Carolina  Od. Inside City Limits
	hours after death with the Maryland tural', or Iteme 23a or 28e-1 ehow Il Exeminer must be ritalified at	Director	Md. NA Sac	ttemne 1. Zip Code	10	g. Citizen of What Cour	1 Mes 2 □ No
	death with me 23a oi	Funeral D	305 n. Monastery Are  11. Marital Status  12. Was Decedent Evy in U.S. 13. Was Enred Forces? 11. Marital Status 12. Was Decedent Evy in U.S. 13. Was Enred Forces?	21259 Decedent of Hispanic Origin? (Specsfy Cuban, Mexican, Puerto	acity Yes or No-	USA  14. Race - Americ Black, White,	
036	ours after iral', or Ite	by	1 Never Married 2 Married 1 Yes 2 No	es 2 No Specify:	riloan, dic.	Specify: B	lack
Maryland 21215-0036	be filed within 72 hours tal Hygiene. d other than "natural; event, Ira Medical Ext	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  NA	Usual Occupation of work done during most of working of use relied) Stodian	ng (	6b. Kind of Business/In	of fice
yland	should be filed within and Mental Hygiene.  I marked other than umailc event, I a M	To Be	Henderson Boyster	18. Mother's Name	in Fl	emingo	,
			Sweette Johnson-daughter 2640 1	And the second s	re Bay	to. md, 2	1230
altimore,	S		20a. Method of Disposition  1 Daurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	till Cem. 8-1	9-06 (	Oc. Location - City or To Shen Buus	ue, md.
Balt	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funery S his Coensee 22. Nam  Court	ne and Address of Facility 27 Promote Ren	o FredHerselton	e Balto. m	d. 21229
	Physician		23a. Perty Enter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. SEPTIC S		or respiratory arre	st,	Approximate Interval Between Onset and Death  1 WEEK
	/Medical Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):  LONG TERM FACIL  Due to (or as a consequence of):  ACUTE PE	LITY ACQUIRE		EUMONIA	10 DAYS
(デ NC 38760,	be executed by sicien and the burial-transit	dical Examine	resulting in death) Last Due to (or as a consequence of):	DISORDE			
LOK6. 0. Box 6	ne death the atte	Physician/Me		pic pregnancy er (specify)		23d. Date of delive Month	ery Day Year
ds. P.	uires that the signed by lid be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.		acco use contribute to to	
ト, Record	sician: The law requires that certificate hes been signed b irector, page 2 should be deta	Completed			24a. Was an autopsy perform	prior to co	opsy findings available mpletion of cause of
1C ital		BeC	25. Was case referred to medical examiner?	26. Place of Death			20140
55 of V	<u>&gt;</u> .₩ ₽	၉	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3[ 27. Manner of Death 1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)	28c. Injury at Work?	me 5 Resider 28d. Describe how	nce 6 Other (Special winjury occurred	(y)
B E Division	or Attenditer deatl	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa		28f. Location (Str. City or Town,	eet and Number or Rura , State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifler (Check out) one)  Certifying Physician: To the best of my knowledge, death occur on the basis of examination and/or investig and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and the of certifier	29c. License number	29	d. Date signed (Month, AUG 14 2	Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PRIYANK DESAL 900 CATON	AVE. BALTI	MORE	MD 212	29
	Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PRIYANK DESA1 900 CATON  31. Date filed (Month, Day, Year)  ALC 1 6 2006	JP.			

			1 - For State Registrar	State of Mary		artment of rtificate of		R	leg. No.	25765				
*	Physicia	an	1. Decedent's Name (First, Middle, Last,	BEST				2. Date of Dear	Day Year	3. Time of Death				
i i	/Medic	2.4	PATRNSSEL 4a. Facility Name (If not institution, give			4b. City, Town,	or Location of De	Augu eath	4c. County of Death	7				
*.	CXdIIIII	ਰ। ਾ ੈ,	Good Samaritan	Hospital		Bal	timore		N A					
	Funeral Director		217-04-9363	7. Age (In 2) 7. Age (In 56	yrs. last birthday) Yrs.	If Under 1 Yea Months Days		rs. 8. Date of Birth (Month, Day)	9. Birth 1949	nplace (State or Foreign untry) MD				
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County N A	100	c. City, Town or Lo Baltime					10d. Inside City Limits 1. Yes 2 □ No				
	with the	i Direc	10e. Street and Number 4308 Mainfield A	venue		10f. Zip Code 21	214	1	10g. Citizen of What Co USA	untry?				
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow or other treumatic event, Ite Medical Exertimer must be notified at	l by Funeral Director	11. Marital Status  1XX Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu	ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Amel Black, White Specify:					
altimore, Maryland 21215-0036	e filed within 72 h al Hygiene. I other than "natu vent, Ira Nedler	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) N A	(Give	dent's Usual Occi kind of work doni DO NOT use retir	e during most of v	working	16b. Kind of Business/l	ndustry				
and 2	ould be fited Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last)  Raymond	Bes		-		Name (First, Middle, ances	Maiden Sumame) Woodley					
Mary	d 2 should be th and Mental t7 is marked treumatic ev	_	19a. Informant's Name/Relationship (T)  Jacqueline Dixon-d					Rural Route Number ne Baltimo	r, City or Town, State, 2 re, MD 21	(ip Code) 214				
more,	Pages 1 and 2 nent of Health a int: if Item 27 is iry or other trea		20a. Method of Disposition  1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)	2		osition (Name of matory or other pi	- 1 -	Date 5 2006	20c. Location - City or Baltimore	Town, State				
Balti	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Licens	s Wa		2. Name and Add			ERAL HOME-E	EAST 21202				
9	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):											
8760,	death certificate be executed eattending physicien and deattending physicien and deatten fransit.	edical Examiner		Due to (or as a co	nsequence of):									
P.O. Box 6	death certifie e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnan □ Other (specify)	cy		23d. Date of deli Month	very Day Year				
	sign d be	leted by PI	Part II. Other significant conditions co	berity	ot resulting in the c	underlying cause g	given in Part I.		obacco use contribute to 'es 2 □ No 3 □ Pro	the cause of death?				
II Reco	The law ate has b page 2 s	Complet		/				24a. Was a autop: perfor	sy prior to death?	topsy findings available completion of cause of 2 \( \sum \text{No} \)				
Vita	Physician: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	fospital:		- 10	thor	Death Check only or						
Division of Vital Records,	Attending Physic death. sctor: After this by the funeral did	ation: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	of 28c. In	4 14015111		lence 6 Other (Speciow intury occurred	cify)				
Divis	el or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		reet, factory, offic	ө	28f. Location (S City or Tow	Street and Number or Ru n, State)	iral Route Number,				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edical (		sician: To the best of moner: On the basis of exa and manner stated.										
	To the within 2 To the complet	ž	29b. Signature and title of certifier	f v-			nse number		29d. Date signed (Montl					
	$\circ$		of French	< n.D			00183	70	MURUST	7/2016				
_	7		30. Name and address of person who c			AN G	OODSA	MARITAN	HOSATE	9,2016 14, MD 243				
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 1 6 2006	SHA SHI 22. Registrar's	Signature	the s								

			1 - For State Registrar			State o	of Ma	ırylan		artme ertifica				lental Hy	Reg. No.	000	5	25766
	Physici /Medi		1. Decedent's Nam											2. Date of De Month	Day	200		3. Time of Death
	Examir		4a. Facility Name (	'If not institution	, give st	reet and nu	mber)			4b. City	, Town, c	r Location	of Death			County of De	ath	
			Frankli	n Squo	re	Hospi	tal		iter		sed er 1 Year	ale	r 24 Hrs.	9 Date of 9		ultin		
	Funeral Director		5. Social Security 1 216 01 8	8163	6. Sex 1 □	M 2□F X	91	in yrs.	last birthday Yrs.	Months		Hours		8. Date of Bi (Month, Di January	14 191	5 Ba	Country Ltin	ce (State or Foreign y) pre, Mary Land
	and w		Usual Residence of 10a. State	10b. County				10c. City	y, Town or l	ocation							100	d. Inside City Limits
	r 28a-f ahow	to	Maryland	Baltim	ore			Balt	timore	County	,							1 ☐ Yes 2 ☐ No
	ith the or 28s	Funeral Director	10e. Street and Nu								ip Code				10g. Citiz	en of What	Countr	y?
	ath wit	rai	8832 Walth	er Blvd.							1234				UŞA			
	ltems	nue	11. Marital Status 1 □ Never Mar	ried 2 Marr		2. Was Dec Armed Fo 1 ☐ Yes			.S. 13	Was Dec If Yes, sp	edent of H ecify Cub	lispanic O an, Mexica	rigin? (Span, Puerto	ecify Yes or N Rican, etc.)	0- 1-	4. Race - Ar Black, W		
036	urs aft	b	3 XWidowed		led	If Yes, Gi	ve Dates:			1 ☐ Yes	2 <b>X</b> No	Specify	y:		5	Specify: W	hite	
5-0	within 72 hours after death with the Maryland with 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 ahow Ita Madical Examinar must be natified at	Completed	(Spe	15. Deceden	t's Educa	ation completed		-	(Giv	edent's Us e kind of w	ork done	durina mo	ost of work	ina	16b. Kin	d of Busine		
2	hen.	mpje	Elementary/Sec			College (		+)	_	DO NOT	use retire	d)			Dol+i	marea (	d bar v	Donad of Ed.
5 2	Hygie ther ther ther ther ther ther there	ပ္	12 17. Father's Name	(First, Middle,	Last)	ŊĀ			Secre	lacy		18. Moth	her's Nam	e (First, Middle			цц	Board of Edu
wt/	wild be Mental arked o	To Be	John J McI									Marth	na Nels	son				
Becker, Ruth	permit. Pages 1 and 2 should be filed within 7 beardment of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, Its Madions.		19a. Informant's N Paul Cvach		hip <i>(Typ</i>	e, Print)								al Route Numb Towson			a, Zip C	Code)
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	- 1 to 1 co	ate	Dr. Wass	nth, Day, Year)	Hit	ri MI) 32. 1	90 Registra	00 F ar's Signa	rank	in Sq	uar	e Dri	ive,	Baltin	ore,	1021	23	7
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			epartment of Health and I Certificate of Death		iene2 (	106	25768		
- Sign		1. Decedent's Name (First, Middle, Last)		2. Date of Deat	h		3. Time of Death		
Physicia		Timothy Scott Barker		August	12.	2006	0525 M		
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	· · · · · · · · · · · · · · · · · · ·	_	ty of Death			
2,4	•	Upper Chesapeake	Bel Air			Harfor	.d		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	tay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign		
Director		219-78-8088 1♥M 2□F 47 Yrs	s. Months Days Hours Min.	July 27	.1959		ryland		
p .		Usual Residence of Decedent							
how	_	10a. State 10b. County 10c. City, Town of	r Location			10	od. Inside City Limits		
9 Ma	cto	Maryland Harford	Forest Hill				1 ☐ Yes 2X No		
ih th	Director	10e. Street and Number	10f. Zip Code	11	0g. Citizen of	What Count	try?		
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or Items 23a or 28a-f ehow event. It a Madical Examinat must be notified at		109 Forest Valley Drive	21050			. S. A			
r deg	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- o Rican, etc.)		ce - America ack, White, e			
or If	by Fi	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No	1 ☐ Yes 2 No Specify:		Speci				
urel	Q P	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					hite		
nat occ	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of wor fe. DO NOT use retired)	king	16b. Kind of I	Business/Ind	ustry		
withir	E	Elementary/Secondary (0-12) College (1-4or 5+)			Couth	antina	Company		
Hygie Ther nt.		8th grade 17. Father's Name (First, Middle, Last)	Carpenter 18 Mother's Nan	ne (First, Middle, M			Company		
od o	Be	Billy Barker Sr.		e la company					
2 should and Men le marke raumatic	၉		New lailing Address (Street and Number or Ru	ty Wenby	City or Tour	State Zin	Codal		
d 2 s th an 7 le			· ·						
1 and Health em 27 ther tr		20a. Method of Disposition 20b. Place of D	2 Martell Ct., Unit		20c. Location		Vn State		
if it or o		i Li bullat 2 Micremation 3 Linemovat ilum State	isposition (Name of crematory or other place)						
rtant njury			Crematory   08/1	6/2006 E	saltimo	ore, M	aryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "naturel", or Items 23a or 28a-1 ehow any injury or other traumatic event. It a Medical Examiner must be notified at OREs.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sc	himunek t	uneral	L Home	Inc.		
			3331 Brehms Lane,			ıkana			
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death		
Physician		Immediate Cause (Final disease or condition resulting in death)	myocardial i	ntanel	700				
/Medical Examiner		Due to (or as a consequence of)	1						
	20	Secuentially list conditions b. Due to (or as a consequence of)							
ed is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Obsease or injury				1			
and and Il-trar	xau	that initiated events c.  resulting in death) Last  Due to (or as a consequence of)	:						
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ate phys	dical	d							
eath certific attending p	by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							
atten for u	jan	in the past 12 months?	3 Ectopic pregnancy			ate of deliver	y Day Year		
the de	ysic	1  Yes 2 No 9 Unknown	5 Other (specify)						
w requires that the death cer been signed by the attendir should be detached for use	유	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tob	acco use con	tribute to the	e cause of death?		
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e 2 s	du	hypertension		24a. Was ai	24b.	Were autop	sy findings available pletion of cause of		
: The	ပ္ပြဲ	n'arcotic overdose		perform Yes 2	nea? !□No	death? 1 ☐ Yes	2 No		
ician sertifi ector	Be	25. Was case referred to medical examiner?		th  Check only on	9/				
hysi this c	ှိ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp		ome 5 Reside			)		
ing F	 	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Tim	w injury occu	rred					
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or At fter o birect in by	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28d. Describe how injury occurred Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred								
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Hos 24 ho Fun fely f	edical	29a. Certifier (Check only and Check on	leath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and mate and place.	nanner as sta , and due to	ited. the cause(s)		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	٠,٠	d. Date sign	ed (Month F	lav Voori		
5.35.8	-		020000						
,		rand 3 Wh	100029	1	AND 1122	-14,20	200		
1		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	11-0	00	210	111		
Cha		31. Date filed (Month, Day, Year)  32. Registrar's Signature	actual isel.	ATIV I	יעוו	~10	17		
Stat Registra		NUC 1 6 2006	Lovely						

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 25769

		1- For State Registrar			Certi	ficate of	Death		, ,	Reg	No Co	UU!	2310
Physici		Decedent's Name (First, Name)								Date of Death Month	Day Yea		B. Time of Death
edical Exami	ner	BENJAMIN  4a. Facility Name (if not inst	HOWA			1.7	City Town	e Loration of		August 12,	2006		0414 hrs
		University Hospita					Baltimore				4c County of	NA	1
Funeral Director		5. Social Security Number	6. Sex		e (In yrs, last		If Under 1 Ye  Months Da		Min		(MM/DD/YYYY	Foreign	place (State or
- Director		131 · 52 · 8814 Usual Residence of Decede		2 F	47	Yrs.				06-11-1	454	Cour	ntry) NY
any		10a. State 10b. Cou			10c. City, To	own or Location	n					1	Od Inside City Limits
<u>* .  </u>	ъ	MD HOV	UARD		cou	MBIA							1 Yes 2 No
Maryl 28a-1	Funeral Director	10e. Street and Number					10f. Zip Code			100	g. Citizen of Wh	at Countr	y?
th the 23a on notifie	<u>=</u>	1561 MURRA			=			U046				ISA	
ath wi	ner	<ul><li>11. Marital Status</li><li>1 Never Married 2</li></ul>	Married	12. Was Decedent Armed Forces?			Decedent of H s, specify Cuba				14. Race White		n Indian, Black,
fter de		3 Widowed 4	Divorced If	1 Yes 2 Yes, Give Year	No	1	Yes 2 X N	o specify			Specify:	BLAC	K
2 hours afte "natural", Examiner	d by	15. Decedent's Education	Specify only	r Dates: highest grade com	npleted) 1		s Usual Occup- st of working lif				16b. Kind of Bu		
5-0036 led within 72 hours after tygiene other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0		College (1-4 or 5	′			e. DO NOT u	ise retired)		222		
5-0036 led within 7 Hygiene I other than	E	12 TH GRAD 17. Father's Name (First, Mi		2 Yr.	3	DA	ILIFF	18 Mother's	Name (Fi	rst Middle Ma	STATE	OF	MD
21215 uld be filec Mental Hy marked of	Be C	BENNIE CU						ROSA	LES		RLEY		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	2	19a, Informant's Name/Relat	ionship (Type	/			Address (Stre		er or Rura		er, City or Tow	n, State, Z	Zip Code)
= = = = = = = = = = = = = = = = = = =		LAURIE G. C	URTIS	(WIFE	)		MURRA'	•			LMBIA	MD	7-4-0-1-0
15 15 15 15 15 15 15 15 15 15 15 15 15 1			ation 3	Removal from Sta	ate cre	matory or other	er place)				20c. Location -		
Baltimo permit Page Department or Important: injury or otd		4 Donation 5 Other 21. Signature of Funeral Ser	r Specify:		MEA	DOWRIE			<u> 19 - 19</u>		EUCRID	GE ,	MD
Balt permit Depart Impor		Vanghn (				VAU	GHN C.	GREE	NE F	UNERAL	SERVIC MO 21	E	
Physician	_	23a. Part I. Enter the disease	e, or complica	ations that caused	the death. D	o not enter the	mode of dying	g, such as car	rdiac or res	Spiratory arres	t, shock, or hea	229 art	Approximate Interval
/Medical Examiner		failure List only one ca Immediate Cause (Final dise	0.	unshot Wound	d to Head								Between Onset and Death
A		or condition resulting in dea	h) Du	e to (or as a conse	equence of):								
	ē	Sequentially list conditions, if any, leading to immediate	b	e to (or as a conse	equence of):				_				
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al rai	an/Medical	UNPENDED		AMENDED									
8760, ufficate be exe ng physician as the burial -	Me	IF FEMALE:	in the	23c. If yes, outcon	ne of pregnar	псу			-		23d Date of	delivery	
68 certifi nding	ian	23b Was decedent pregnant past 12 months?		1 Live birth 4 Pregnant at	time of death	2 Fera		Ectopic p	oregnancy		Month	Day	Year
ires that the death cer signed by the attendi	Physicia	1 Yes 2 No 9	I Imlemateur	9 Unknown		5 Oth	er (Specify)						
O. lat the	by P	Part II. Other significant co	nditions co	ontributing to death	n but not resu	ifting in the un	derlying cause	given in Part	: I.				e cause of death?
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cords, law requir	Completed									24a Was an autopsy	, Б	rior to con	osy findings available inpletion of cause of
Rec The la	등									perform 1 <b>V</b> Yes 2		eath? ✓ Yes	2 No
tal Recian: The	Be (	25. Was case referred to me examiner?		nutal —				e of Death (C	heck only	one)			
of Vital Records,  ng Physician: The law requir  After this certificate has been si  meral director, page 2 should b	P	1 ✓ Yes 2 No 27. Manner of Death	1103	pital. 1 Inpatre		R/Outpatient Bb. Time of Inj		Other <sub>4</sub> I	Nursing He		esidence 6	Other:	
ion of tending Ph eath tor: After t	Certification:	1 Netural	Pending	Aug 12, 2006	ear) 0	256 hrs		Yes 2 V	ISu	bject shot	w injury occurre	ea	
Division tal or Attendin ts after death al Director: A	fica	. —	nvestigation Could not be	2Be. Place of Inj	jury - At hom	e, farm, street	factory, office	building, etc.	28f			r or Rural	Route Number, City
Divisior spital or Attenchours after death neral Director:	Serti.		letermined	(Specify) Par	king Lot				167	or Town, Sta 76 Annapo	<sup>te)</sup> olis Rd., Ode	enton, <b>f</b>	∕Id.
Fu Fu	edical (	29a Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: Examiner: O	To the best of my	knowledge,	death occurre	ed at the time, on	date and place	e, and due	to the cause(	s) and manner	as started	l.
To the within To the comple	Med	29b Signature and title of ce	ar	nd manner stated			29c. Licen				29d Date signe		
		( a MAC	) [la	R 00 at	1 -			.M.E.			August 12,		,,
10		30. Name and address of pe	son who con	npleted cause of de	eath (Item 23	sa)				J.,			
				Medical Exan	niner 1	11 Penn St	reet, Baltin	nore, MD 2	21201				
St Regist	ate	31. Date filed (Month, Day, Ye	. 000	32. Registrar	-	e As	ules.						
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			For State Registrar	State of Maryla	•	rtment of Healt			iene	06	25770
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	V	3. Time of Death
	Physicia		JAMES ROMED	CHA8E				08.09.	2006	Year	10:50 PM
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	-	4b. City, Town, or Local	tion of Death			y of Death	
			GENESIS HEAL	TH CARE		SEVERNA					
	Funeral		5. Social Security Number 6. Sex	M 005	s. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign litry)
H	Director		105 - 10 - 3209 180 Usual Residence of Decedent	96	113.			04.04.	1404		IVID
	land wo		10a. State 10b. County	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	Many	ţċ	MD	GL	EN BI	URNIE					1 ☐ Yes 2 🖪 No
	or 28¢	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of		ntry?
	23a	al	1931 COVINGION	J AVE		2106				USA	
	er dez	Funeral	TI, Maria States	Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hispani f Yes, specify Cuban, Me	ic Origin? (Spec exican, Puerto F	cify Yes or No- Rican, etc.)		ce - Americ ick, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 M Yes 2 □ No If Yes, Give Year or Dates:		☐ Yes 2 No Spe	ecify:		Speci	b: BLA	CK.
5-0036	2 hou etura	ted	15. Decedent's Educ		16a. Deced	lent's Usual Occupation	most of working		16b. Kind of E		
212	thin 7 en "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	_	kind of work done during OO NOT use retired)	most of working	9	2411	20.40	
2	ed wil	Con	unk		CHAU	LFFER			RAILE		
Maryland 2121	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "netural", or Items 23a or 28e-f show afte event, the Medical Ever in art most te notified at	Be	17. Father's Name (First, Middle, Last) FRANK CHASE			18. N	Mothers Name	(First, Middle, M	лаідөп Бита	me) wik	
<u> </u>	should ind Men s marke umatic	ဥ	19a. Informant's Name/Relationship (Type	ne Print)	19h Mailin	g Address (Street and N	lumber or Rural	Route Number	City or Town	. State. Zic	Code)
Ma	d2s th an 27 is :		LEROY POTTS (	sou)	3400	OAKFIELL	) AVE	<b>~</b>	-	. ~	21216
re,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b.	Place of Dispo			, -	20c. Location		
Ê	Pages nent of nnt: If it ury or o		1  Burial 2  Cremation 3  Re  `4  Donation 5  Other (Specify)	emoval from State	· REST	natory or other practs	08.15	· Dla H	ANOVI	ER.	MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or Items 23a or 28e-f show entry injury or other treumatic event, the Madical Eventiant remail to notified at once.		21. Signature of Funeral Service License	~ 1	provide a	Name and Address of F					
<u> </u>	20E 5 8		Daugh (	4	51	51 BAUD. NA	AIL PIK	E BAU	O. MI	0 212	29
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the de- e cause on each line.	ath. Do not ent	er the mode of dying, suc	ch as cardiac or	r respiratory arre	est,		Approximate Interval Between Onset,and Death
	Physician		Immediate Cause (Final disease or condition	ISCHE	MIC	CARDIC	my,	DPAT	144		YEARS
ı	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	10-100	. >	10101	-		115000
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):	MILIER	4	DISLEA	26	-	704/3
_	uted I Insit	min	cause. Enter Underlying Cause (Disease or injury		,					N.	
<b>်</b>	execting and ital-tra	Examin	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):						
8760,	cate be executed physician and the burial-transit	dical	<b>€</b> d								
9	ntifica ing ph e as th	Med	IF FEMALE:				-				
Box	ath ce ttendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnancy				ate of delive onth	ery Day Year
<u>.</u>	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5L	Other (specify)					
P.O.	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	/ Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying cause given in I	Part I.	23e. Did tob	acco use cor	ntribute to t	ne cause of death?
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Be	sicien: The law certificate has birector, page 2 s	Completed						autops perform	ned?	death?	2 No
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<u></u>	Physicien: r this certifica ral director,	To E	examiner? 1 ☐ Yes 2 No		☐ ER/Outpatier	- f		ne 5□Reside			y)
n c	ing P		27. Manner of Death  Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	_	.8d. Describe ho	w injury occu	irred	
Division of Vital Records,	Attending it death. ector: After by the fune	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm str	M 1 ☐ Yes		28f. Location (St	reet and Num	ber or Rura	al Route Number,
<u>&gt;</u>	after Direction by	ertif	4 ☐ Homicide determined	building, etc. (Spec	cify)	oot, taggery, amou		City or Town			
_	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	ician: To the best of my k	nowledge, deat	occurred at the time, da	ate and place, a	and due to the ca	ause(s) and n	nanner as s	tated.
	he Ho in 24 l he Fu oletely	edical	(Check only 2 Medicel Exemir	ner: On the basis of examinand manner stated.	nation and/or in						
	To the To the Comp	ž	29b. Signature and title of certifier	30		29c. License num	nber	2	9d. Date sign	ed (Month,	Day, Year)
			1 Di Con	Mely		1/31	156		Huon	ST 1	4,2006
	5		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	1)31 9005 K	11 80	1015 1	N AA	1 -11	21236
	Sta	ato	31. Date filed (Month, Day, Year)	32. Registrar's Sig	hature.	(00)	-1-0/	ive K	U ISM	0110	· alla Ma
	Regist		AUG 1 6 20	06	S. A						

State of Maryland / Department of Health and Mental Hygiene 4 U U b 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day August 9 2006 **Physician** 22 30 Robert Ensor Cofiell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30 1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Days Hours Months Min 62 Baltimore, Maryland Director 212 38 1994 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Completed by Funeral Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Maryland Avenue Apt D 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2/CXNo Specify: White Maryland 21215-0036 Specify: 3x Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) WĂ 6 Factory Worker Factory other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny lighty or other traumatic events. Carroll Cofiell Annabel Ensor ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 Quintara St. San Francisco, California 94116-1265 Ronald Cofiell Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery August 14 2006 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DSME Pnysician Conneci 42915 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner A pue attending physician and T Due to (or as a consequence of) 00+ie/l 00+ie/l Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ormed? 2.⊠No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) New Pice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Yes 2 No SIL 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2000 D5830) 10 30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print) works, M 6601 N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 6 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <u>AUGUST</u> 14 2006 12:00A M FRANCES GENEVIEVE CLIFT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESLEY HOME BALTIMORE CITY BALTIMORE CITY 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day Y 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\X 98 Yrs. Director Virginia 217-36-3685 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Itama 23a or 28a-f eho: treumstic event, the Medical Examinar must be notified at 1 √Yes 2 No Director Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2211 West Rogers Avenue 21209 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ¥ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. 4 yrs. Housewife Housekeeping-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ital and Menta Clarence V. Elmore Jane Zehmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Clift (Son) f Heelth 2421 Hillford Drive Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If Ite
any Injury or ot
once. X1XXBurial 2 Cremation 3 Removal from State Gardens of Faith CEm. 8-17-2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Sign to e of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence 6 Examiner Theroscleration Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) g physician end g certificate be executed resulting in death) Last Due to (or as a consequence of). Physician/Medical signed by the attending d be detached for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 and person. ormed? 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🌣 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) iberts, MO. 21464 who completed cause of death (Item 23a) (Type, Print) Rosert LiBerto 508 BANK ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 11 11 5

			1 - For State Registrar	State of Maryland / Department of Health and Mental Hygien  Certificate of Death  Reg. N	
	Physici /Medic		1. Decedent's Name (First, Middle, La	2. Date of Death Month AvgoSt	3. Time of Death 3:00 PM
4	Examir	ner	4a. Facility Name (If not institution, gives the Science Hospital Security Number 6.5.	a) of Baltimore Baltimore City	c. County of Peath  9. Birthplace (State of Foreign
	Funeral Director			Yrs. Months Days Hours Min. (Month, Day) Yea	31 MARGIANO
	ne Marylan 8a-f show	ector	10a. State 10b. County	BAILIMOLE COUNTY	10d. Inside City Limits 1 ☐ Yes 2
	s 23a or 2	ral Dire	10e. Street and Number CECIA	R Hill 21/33	Citizen of What Country?
9000	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Modical Expublicational be profiled at	d by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armoef Forces?  1. ☐ Yes 2 ☐ No  If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☐ No Specify:	14. Race - American Indian, Black, White, etc.  Specify: BACK
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, it is Medical Exaction from Item refilled at	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation (Give kind of work done during most of working file. ONOT use retired)  4 college (18 f. 5)  What is a second of work done during most of working file. ONOT use retired)	Kind of Business/Industry UNEICH NQUSTRY
Maryland	should be filed nd Mental Hygir marked other imatic event, II	To Be (	Father's Name (First, Middle, Last,	P.CARCOIL GOLDIE CLUT	n Sumame)
	1 and 2 sh Health and em 27 is m ther traum		19. Informan's Name elations in (	19b. Mailing Address (Street and Number or Rural Route Number, City  19b. Place of Disposition (Name of Date 20c.	for Town, State, Zip Co. e) 2/2/7 HD HU WO. L cation - City or Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Sign, ture of Funeral Şervice Licet	Premoval from State GARGON - TO CEST 8-23-06 CM	) jugg Mills Md. Trooce Cremation-
	20 5 5 3		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.	Approximate Interval Between
1	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	Priset and Death
58760 <sub>x</sub>	icate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	
P.O. Box 68	death certif e attending id for use a	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)	23d. Date of delivery Month Day Year
	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of		o use contribute to the cause of death?
Vital Records,	The ate h	Completed		24a. Was an autopsy performed? 1 □ Yes 2 □	
Zit	Physician: The this certificate har all director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence	€ □Other (Specific)
n of	ng Phys fter this ineral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28d. Describe how interest Work?	
Division	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		and Number or Rural Route Number, ite)
_	To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)  1 Certifying Properties of the control of the certifying Properties of the certifying Properties of the certifying Properties of the certifying Properties of the certifying Properties of the certifying Properties of the certifying Properties of the certifying Properties of the certifying Properties of the certified Properties of th	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause( niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date at and manner stated.	s) and manner as stated. nd place, and due to the cause(s)
	within 2 To the	×	29b. Signafure and title of certifier	Ihmad, ND Doob 3198 Au	eate signed (Month, Day, Year)
	70		30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death (Item 23e) (Type, Print)  HNWCO Sirver HOSPITAL OF 32 registrar's Signature	Baltimore
	Sta	ite	ALIC 1 6 20	OB Branch He Boards	

# Please Type or Print in Black Indelible Ink

Catherine Cole	1- For State Certificate of Death	Reg. No. 2006 2577
Physician/ Medical Examiner		2. Date of Death Month Day August 12, 2006  August 12, 2006  August 12, 2006  August 12, 2006
nedical Examine	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
Funeral	Maryland General Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	N / A  8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director	212-74-0109 1 Months Days Hours Min.	03/09/1953 Foreign MARYLAND
any	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location	10d. Inside City Limits
<b>8</b> ."	MD N/A BALTIMORE CITY	1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number         10f. Zip Code           1709 N. CAREY STREET         21217	10g. Citizen of What Country? USA
er death with tl	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1) Never Married 27. Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - American Indian, Black, Rican, etc.) White, etc.
ter death ", or ite er must	1 Never Married 2XXMarried 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No specify:	Specify:
hours aft natural" Examine	or Dates:	vork done 16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) COOK/DIETARY AIDE	HCR MANORCARE
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media		(First, Middle, Maiden Surname) E PATTERSON
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21217
e, MD and 2 sho fealth and item 27 is traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite	1 Name   2   Cremation   3   Removal from State   WOODLAWN CEM.   8 / 1   Donation   5   Other Specify:	17/06 BALTIMORE CO, MD
Balti permit. Departu Imports Injury o	21. Signal Funeral Service Licens 22. Name and Address of Facility H(	OWELL FUNERAL HOME 2 207 EIGHTS AV, BALTIMORE, MD
Physician	23 Par I is a sease, or complicity in situation and the part to not enter the mode of dying, such as cardiac of the last trip one cause on each line.	
/Medical Examiner	Imm diate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):	Death
- /	Sequentially list conditions, b	
ted misit	cause. Enter Underlying Cause (Disease or injury that initiated  Levents resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
and transit	events resulting in death) Last Due to (or as a consequence of):	
760, crate be executed physician and the burial - transit	UNPENDED AMENDED  IF FEMALE:  23c. If yes, outcome of pregnancy	23d. Date of delivery
Sox 687( leath certifica e attending pt for use as the	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant in the past 12 months?	
). Box 687 the death certific by the attending I ched for use as th	1	
, P.O. res that the signed by be detach		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacertification: To Be Completed by Fertification: To Be Completed by Fertification:		24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
tal Reccion: The lar certificate ha ector, page 2		performed? 1 Yes 2 ✓ No 1 Yes 2 No
Vital Recystian: The librate of the Court of	25. Was case referred to medical examiner?	g Home 5 Residence 6 Other:
n of Vi ling Physi  After this funeral dir		28d. Describe how injury occurred
Division o spital or Attending tours after death. The filled in by the function of the functin	Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Divis spital or At shours after d neral Direct filled in by Certifica	Suicide 6 Could not be determined (Specify)	or Town, State)
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical Ex	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	
Me de de de		29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	August 12, 2006
2	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	
State Registrar		
DHMH 17 Rev 1/2001	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 11:20a Catherine Marie DeLancey 15, 2006 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3517 Ellen Drive Westminster Carroll Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days 1 □ M 2 □ F Months Hours Yrs. 212-80-8192 48 Director July 13, 1958 WVUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits a strong when the highest and well to them size of 28e-f show is marked other then "naturel", or items 23e or 28e-f show raumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 √ No Carroll Directo Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3517 Ellen Drive 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Procurement Analyst US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gaylord Barker ဨ Margaret Dawson of Health and Nitem 27 Is mail other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. K. Alan DeLancey (Spouse) 3517 Ellen Drive Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō = 1 

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny Injury or QDGE. 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery 8/19/2006 Westminster, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Mian Hackt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sykesville, MD 21784 (410)-795-1400 Approximate Interval Between Onset and Death Brees The Immediate Cause (Final disease or condition Physician Laurenoma yrs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2DNo 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury s after dea. 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

Registrar

State

380

Progress

1 6 2006

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Way

37 Registrar's Signature

D33681

Elders burg, mp

michael

8-15-06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** کن ت 10:00 PM ntwan 2006 AUGUST 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE T AGNES If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day July 25) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X**M 2□ F 216-17-0776 Yrs. mary **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner rount be notified at 1 ☐ Yes 2 ☑ No Baltimore Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 21 Married 1 Never Married 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alewa Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) as ear permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Important: if item 27 is marked other any, njury or other traumatic event, 2006 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be orithe a lar ဨ na Vis 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilles Ville 605 Leafy dale imace , md, 20a. Method of Osposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donayion 5 □ Other (Specify) Rusdowne 22. Name and Address of Facility 3 405 w. 21. Signature of Funeral Service Linense-Funeral Sen, Baeto, md, 21229 m. wallace nancy Part : Enter the disease, or complications that caused the death. Do not enter the mode of thying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1-24EARS OBSTRUCTIVE SLEEP APNEA **Physician** /Medical Due to (or as a consequence of) Examiner PULMONARY EMBOLISM PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ate has been signed by the e page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBESITY 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 22 No ours after death.

neral Director: After this certifical filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be o ۵ of Vital Records, Division or Attending

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Baltimore, Maryland 21215-0036

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State Registrar

Medical

29a. Certifier

Caton 31. Date filed (Month, Day, Year)

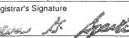
29b. Signature and title of certifier MANPREE T

16

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





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Balti

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 15 For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Dockery **Physician** Mildred 2006 10120 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Jinai Hospital SOMHIMO a Himore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 3-19-19 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 25/F 87 Md. Director 215-16-5520 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at Baltimore 1 X Yes 2 ☐ No NA Md. Directo the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 3004 Clifton Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Peges 1 and 2 should be fil tment of Heelth and Mental H tant; If Itam 27 te markad ott Bailey Georgiana Gross George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 s Depertment of Heelth an Important: If Itam 27 is any injury or other trau 2005. 1123 Darley Ave., Baltimore, Md. Evangeline Burrell Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Md. 8-16-06 Mt. Carmel Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. E. , Baltimore, wan 21202 1101 E. North Ave. Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OLITIS week **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, use est IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 2 DNO 3 Probably 4 Unknown 1 🗌 Yes been sig 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has I lirector, page 2 s autopsy performed? 1 ☐ Yes 2 10 NO or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Department 2 EP/Outpatient 3 DOA ို 1 Tes 2 TNo After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 D Matural М 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funerel Director:, completely filled in by the f 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar

31. Date filed (Month, Day, Year) AUG 1 6 2006

anarva Sthrad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

amarina



Sirai Hospital

29c. License number

1006319

29d. Date signed (Month, Day, Year)

August 13

Docker

06-05936 Spencer Davis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 25778

		I - For State Registrar		C	ertifica	ate of L	Death			Reg No	o	JUH	0 2011		
Physicia	ın/	Decedent's Name (First, Middl	e,Last)						2. Date of D Month	eath Day	Year		3. Time of Death		
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	Ļ	4a. Facility Name (if not institution  Johns Hopkins Bayvie	-	mber)			. City, Town, oi Baltimore	r Location of			tc. County o				
Funeral Director		5. Social Security Number 218–46–8995	6. Sex	7. Age (In yrs		nday) Yrs.	Months Day		24Hrs 8. Date of Min.	Birth (MN	M/DD/YYYY) L <del>946</del>	Foreign	nplace (State or ntry) Md.		
	ŀ	Usual Residence of Decedent							14/0/1	<i>31 1</i>					
v any		10a State 10b. County		10c. C	ity, Town	or Location	1						10d Inside City Limits 1 X Yes 2 No		
Maryland 28a-f show any dat once.	ĕ	Md.	NA		Ba	altim				1 10 0					
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 3105 Brendan	Ave.				10f. Zip Code 212	213		10g C	itizen of Wh		try ?		
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2 hours afte "natural",   Examiner	g by	15. Decedent's Education (Spe-		de completed			Usual Occupa		nd of work done	16b	Kind of Bus		· ·		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Spencer	Mel	vin	]	Davis	, Jr.	Ma	ry	Diar	ne	C	Coleman		
imore, MD 2121 Pages I and 2 should be filment of Health and Mentall taut: If item 27 is marked or other traumatic event,	<u>۲</u>	Mr. Spencer M. Davis, Jr. Father 3038 Mayfield Avenue, Baltimo													
e, h I and Health Fitem	20a Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or other place)											City or 7	own, State		
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and N Important: If item 27 is in injury or other traumatic.		4 Donation 5 Other Sp	pecify:	om State		Zion	Cem.	o of Famility	8-16-06	I	Lansdo	wne,	Md.		
Balti permit Departu Importi injury	-	Mt. Zion Cem. 8-16-06   Lansdowne, Md.  Signature of Funeral Service Licensee   22. Name and Address of Facility   March F.H. East   1101 E. North Ave., Baltimore, Md. 21202													
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8760, tificate bing physicas the burner as t		IF FEMALE: 23b. Was decedent pregnant in the	23c If yes,	outcome of p	regnancy	Feta		Ectopic		2	3d. Date of Month	delivery D	av Year		
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Division of Vital Records, tal or Attending Physician: The law requir is after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed by								pe	erformed'	? d	eath?			
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Division Spital or Attent hours after death meral Director:	Certification:		Id not be (Specify)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or Tow unk	n, State)					
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To the within. To the comple	Med	29b. Signature and title of certific	and manner s	stated				ise number					th, Day, Year)		
		Cardle	- Ha	lla	In		0.0	.M.E.		Αι	igust 11,	2006			
		30 Name and address of person Carol Allan, MD As	who completed cau			Penn S	reet, Baltin	nore MD	21201						
9	ate	31. Date filed (Month, Day, Year)													
Regis		AUG 1 6 2	006	egistrar's Sign	5. A	A TOWN									

			For State Registrar	State	of Marylan	•	artment of H		d Menta		- Z U U i	25779
			Registrar  1. Decedent's Name (First, Middle	le. Last)		Cel	rtilicate of L	Jeam	2. Date	Reg. e of Death	No.	3. Time of Death
в	Physicia	_	Calle Mas	2801	De	2015	r		Mo	nth UG	Day Year	3:40 PM
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)	7-10-0	4b. City, Town, or	Location of E			4c. County of Dea	
			8815 Stoneri	dge Circ	cle #1		Pikesv:				Balti	
	Funeral		5. Social Security Number	6. Sex 1 <b>K</b> JM 2□ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours !	Min. (Mo	e of Birth onth, Day, Ye	ear) C	thplace (State or Foreign ountry)
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	nyland how		10a. State 10b. County			y, Town or Lo						10d. Inside City Limits
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က	or Hen	F	1 Never Married 2 Mar	ried 17-Yes	Forces? 2 □ No				Puerto Rican, i	etc.)	Black, Whi	te, etc. rican-
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	1 end Healtl em 2		Kathleen F. D  20a. Method of Disposition	ennis/ v.	20b. P	lace of Dispo	osition (Name of		Date		c. Location - City or	
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event, Italian once.		1 Burial 2 Cremation 4 Donation 5 Other	3 ☐Removal from	n State Gar	emetery, crei	matory or other place Forest	8/	18/06	Ow	ings Mi	11s, MD
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П			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that only one cause or	t caused the death	1						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	1150		TIUS	OFU	MITC	es		
1	/Medical Examiner		,	Due t	o (or as a conseq	uence of):						
		Jer	Sequentially list conditions, if any, leading to instructions	b. — Just	o (or as a conseq	uence of).						
	and i-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
760,	ate be executed  ysicien and he burial-transit		resulting in death) Last	Due t	o (or as a conseq	uence of):						
687	e y e	dical		d								
Box 6	death certifica e attending ph id for use as th	J/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna						23d. Date of de	slivery
	death e atte ed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		e birth 2 ☐ Feta gnant at time of d		□Ectopic pregnancy □ Other (specify)				Month	Day Year
P.0	The law requires thet the de vie has been signed by the a bage 2 should be delached i	Physician/Med	9 Unknown	-						Did to the		o the cause of death?
	ires the signed d be de	þ	Part II. Other eignificant condit	OTO P					23	1 ☐ Yes	4	robably 4 Unknown
Vital Records,	w requir been si should	ompleted	Nuce	Tension			<u></u>		24	a. Was an		utopsy findings available
Re	The lav	dmo	17/14	LIENG/UL	7				_	autopsy performe	d? prior to death?	completion of cause of
ita		ပ	25. Was case referred to medical	al				26. Place of	f Death   Chec	Yes 🕦	HNO ILITE	s 21 NO
of V	S 5	To B	examiner? 1 ☐ Yes 2,€€©0			ER/Outpatie	nt 3 DOA Othe	er: 4 ☐ Nursi	ing Home	Pesideno	e 6 ☐Other (Spe	ecify)
o no	After	iuo	27. Manner of Death  ↑ Hatural 5 ☐ Pendi	9	te ot Injury onth, Day Year)	28b. Time of Injury	Work			escribe how	injury occurred	
Division	ten feat for: the	icat	3 ☐ Suicide 6 ☐ Could		ce of Injury - At he	ome tarm st	M 1 1 1	Yes 2 □ No		cation (Stree	et and Number or R	tural Route Number.
Div	after after Direction	Certification;	4 Homicide determ	mined 200. Fla	lding, etc. (Specif	<b>y</b> )	,,,			y or Town, S		
	To the Hospitel or At within 24 hours after to the Funerel Direc completely filled in by		29a. Certifier 1 Certifyi	ng Physician: To t	the best of my kno	wledge, deat	th occurred at the time	ne, date and p	place, and due	e to the caus	se(s) and manner a	s stated.
	To the h within 24 To the F complete	Medicai	one) 29b. Signature and title of certifi	and ma	anner stated.		29c. License				. Date signed (Mon	•
1	To Wit		230.39	18/10	O		アノフ	-174	1		8-15-	2005
	10		30. Name and address of person	who completed ca	nuse of death (Iter	п 23а) (Туре,	Print)	100	1	11	8-15-	0
	10		STE 120	1410	Knel	101	In G	Seals	Le.	Md	210	45
	Sta Registr		31. Date filed (Month, Day, Year AUG 1		. Jegistrar's Signa	ature H A	and a					
	negisti	GII	70u + 0	2000	MINING I	J. 19	AD THE					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** August 12 2006 10:00P™ Elizabeth Eberling /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Vantage House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 2,1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months 1 ☐ M 2 ☐ F Jan. 214-30-4631 94 Yrs Germany Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nem 47 te marked other than "naturel", or items 23e or 28e-1 show other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 XNo Columbia Maryland Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21044 5400 Vantage Point Road death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2+ Elementary/Secondary (0-12) Piano Teacher Music 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Health and Mental Ida Joepgen Paul Heilmann ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 4107 Woodberry Street University Park, MD 20782 Richenda Shihab (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Depertment of FImportant: If Ite
eny injury or ot 1 ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8-18-2006 Baltimore, Maryland New Cathedral Cem, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee tzke Funeral Homes, Inc. 55 Twin Knolls Road Columbia, Maryland 21045 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sauentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physiclan: The law requires that the death certificate be executed use as the burial-transit the attending physicien and P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day Year jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No page 2 should be deteched 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 1 Yes 2E No 2.2 No 1 ☐ Yes director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA ald 413 Consticon 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1-6 2006

**ORIGINAL** 

			1 - For State Registrar	State of	Marylar				ealth a Death	and M	lental Hy	Reg. No	2006	257	8
Ŕ.,	Physici	an	1. Decedent's Name (First, Middle, Las	1)							2. Date of De Month	aath Day	/ Year	3. Time of D	
20,00	/Medic		James David Elliott, Sr								08	10	200	9	-C( M
e	Examir		4a. Facility Name (If not institution, give		ber)		,		Location o	of Death		40.	County of De	ath	
			1400 East Madison Stree  5. Social Security Number 6. Se		7 Ann (In vrs	last birthday)		imore	City If Under:	24 Hrs.	8. Date of Bir	rth	n/a	irthplace (State or F	Foreign
	Funeral Director		1)	_M 2□F	. Ago (iii yi s.	75 Yrs.	Months		Hours	Min.	(Month, Da	ay, Year)	3.0	Country) MD	Or engar
	•		220-20-3001 Usual Residence of Decedent			13					11-02-	1727_		עניו	
	how		10a. State 10b. County			ity, Town or Lo								10d. Inside City	
	e Ma	ctor	MD n/a		Bal	timore C	ity							1 💢 Yes 2	!∐No
	or 28	Director	10e. Street and Number				10f. Zi	p Code				10g. Cit	izen of What (	Country?	
	23e		1400 East Madison Stree	et						205			USA		
	er de	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	J.S. 13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	spanic Orig n, Mexican	gin? (Spi i, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - An Black, Wh	nerican Indian, nite, etc.	
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes If Yes, Give	2   No		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify:	D11-	
Ş	72 hours after death with the Maryland natural, or Items 23e or 28e-f show dical Examiraer must be nutified at		15. Decedent's Ed	Year or Da	tes: 1950	16a. Dece	dent's list	ial Occup	ation			16h K	ind of Busines	Black	
75	in 72 n° n	Completed	(Specify only highest grad	de completed)	-3	(Give	kind of wi	ork done d	turing most	t of work	ing	100.10	and or business	amoustry	
212	within liene. r then	шо	Elementary/Secondary (0-12) 8th	College (1- n/a	40r5+)			drive	r			Yello	ow Memt.	Co.	
0	Hygi other	O	17. Father's Name (First, Middle, Last)						18. Mothe	ır's Name	e (First, Middle	-			
a	should be nd Mental marked c	To B	David Turner						Elsi	e E11	iott				
ary	and Ment ie marked		19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Addres	s (Street a	an <i>d Numb</i> e	or Rur	al Route Numb	er, City o	r Town, State	Zip Code)	
Σ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the Marylan them 23 or 28a-f show item 27 is marked other then "natural", or Items 23e or 28a-f show other treumatic event, the Machical Exemiliar must be notified at		James D. Elliott, Jr	son		_ 627 N.	Grant	ley S	treet;			d 21:	229		
Baltimore, Maryland 21215-0036	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location · City									ocation · City o	or Town, State		
Ĕ	Pages nent of I ent: If it		4 Donation 5 Other (Specify	rison Fo	rest \	7etera	n   (	08/17	/2006	Owi	ngs Mill	s, MD			
a	permit. Pag Depertment Importent: I eny injury o		21. Signature of Funeral Service Licen:	600	22	2. Name a	nd Addres	s of Facilit	w <sub>1</sub>	ie Funer	al Hor	me. P.A.			
_	#Q = 9 9		Juneila (	Janes						et; B	altimore	, MD			
ì	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. MY	ach line.	DIAL								Approximate Interval Betwee Onset and De	ath
8760,	death certificate be executed e attending physicien and defor use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse										
.O. Box 6		Physiclan/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2∏Fet ant at time of	al death 3	⊒Ectopic p ⊒ Other (s						23d. Date of d Month	elivery Day Yea	ar
σ.	de de	by Pi	Part II. Other significant conditions co	ontributing to de	ath but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Did	tobacco u	ise contribute	to the cause of dea	ath?
S	n sign		DIABETES N	IELLI	rus						1 🗆	Yes 2	□No 3□I	Probably 4 Muni	known
of Vital Records,	aw requir as been si 2 should	Completed	HYPERTENSI	ON							24a. Was		24b. Were	autopsy findings av	ailable
R	The har age	E									auto perfe	psy ormed? 2.⊠KNo	death?		se of
ta		0	25. Was case referred to medical						26. Place	of Deatl	h (Check only		1011	3 24 110	
>	N P	To B	examiner? 1 X Yes 2 ☐ No	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatie	nt 3 🗆 D	OA Othi	ar: 4 □ Nu	rsing Ho	me 5 Res	idence	6 □Other (Sp	ecify)	
			27. Manner of Death 1 KNatural 5 □ Pending	28b. Time o		28c. Injun Worl			28d. Describe						
Division	ten for: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	nome, farm, st.			763 2		28f. Location ( City or To			Rural Route Numbe	3r,		
	To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by	edical C	29a. Certifier 1 Certifying Ph. (Check only one) 2 Medical Exam	owledge, deat ation and/or in	h occurred evestigation	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s)	and manner of place, and di	as stated. ue to the cause(s)			
	To the Vithin 2. To the complet	ž	29b. Signature and title of certifier					c. License	_	,				nth, Day, Year)	
	/		· Cound	reci	MD			032	2186	5		08	-15	-2001	6
	'n		30. Name and address of person who												
	J		CONRAD MAY				ENE	ST.	, 13.	ALT	MOR	EM	10 21	20/	
10 mg	Sta Regist		31. Date filed (Month, Day, Year)  ALIC 1 6 2006	32. Re	egistrar's Sign										

DHMH 17 Rev 1/2001

ORIGINAL

	_1	State Registrar		aryland / [	Certifical				Reg	. No.		
ian		Decedent's Name (First, Middle, La FANNYE	*		ENGLE	=		N.	Date of Death Month AUIUIF	Day	Year 200 (	
lical iner		4a. Facility Name (If not institution, give		re	4b. City	, Town, or	Location of D		10/041	4c. Cour	nty of Dea	1/
il r	5	5. Social Security Number 6. S	1	ge (In yrs. last bir 86	thday) If Unde Yrs. Months	r 1 Year Days	If Under 24 Hours		Date of Birth	920	9. Bi	inthplace (State of Country)
tor	1	Usual Residence of Decedent  10a. State 10b. County  MD N	I/A	10c. City, Tow	n or Location							10d. Inside Ci
Il Director	1	10e. Street and Number 3024 FALLSTAFF R	ROAD		10f. Zi	p Code	21209		109	g. Citizen o	of What C	Country?
by Funeral		11. Marital Status 1 □ Never Married 2 □ Married 3 ፟ Widowed 4 □ Divorced	12 Was Decedent Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		lispanic Origin an, Mexican, P Specify:	? (Specify Puerto Ricar	Yes or No- n, etc.)		Black, Wh	nerican Indian, ite, etc.
Completed		15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5	5+)	Decedent's Usu (Give kind of we life. DO NOT u	ork done o	during most of	f working		AKER		s/Industry
To Be C	1	17. Father's Name (First, Middle, Last NATHAN	t)	S	TONE		18. Mother's ZELDA		st, Middle, Ma	niden Sum	ame)	(UNKN
		19a. Informant's Name/Relationship DEANNA WERTZ / D			. Mailing Addres					-		
	2	20a. Method of Disposition	_	comoto	f Disposition (Na	ime of	i	Date	20	c. Locatio	n - City o	r Town, State
Tile 8		4 Donation 5 Other (Speci			SRAEL CE 22. Name a	METE	RY 08	SOL L	EVINSO	N & E	BROS.	ORE, MD
The state of the s		4 □ Donation 5 □ Other (Special	ensee Addu mplications that caused y one cause on each life a	BNAI I	SRAEL CE 22. Name a 8900 E not enter the mo	EMETE nd Addres REIST	RY 08 ss of Facility TERSTOW	SOL L IN ROA	EVINSO D - PI	N & E KESVI	BROS.	
ľ		4 Donation 5 Other (Special Signature of Funeral Service Lice 21. Signature of Funeral Service Lice 22. Signature of Funeral Service Lice 22. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to introductions are listed cause. Enter Underlying Cause (Disease or injury)	ensee Addu ensee Addu inplications that caused y one cause on each life a	BNAI I  d the death. Do ine.	SRAEL CE 22. Name a 8900 F not enter the mo	EMETE nd Addres REIST	RY 08 ss of Facility TERSTOW	SOL L IN ROA	EVINSO D - PI	N & E KESVI	BROS.	, INC. , MD 212
Examiner		23a. Part1. Enter the disease, or constock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a year line to the Testiate Cause. Enter Underlying	ensee Addunguise on each ling a	d the death. Do ine.	SRAEL CE 22. Name a 8900 F not enter the mo	EMETE nd Addres REIST	RY 08 ss of Facility TERSTOW	SOL L IN ROA	EVINSO D - PI	N & E KESVI	BROS.	, INC. , MD 212
Examiner		4 Donation 5 Other (Special Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a year high to him solistic cause. Enter Underlying Cause (Disease or injury that initiated events	ansee Additions that caused y one cause on each ling.  a	BNAI I  d the death. Do ne.  WWW. a consequence a consequence a consequence of pregnancy Consequence	SRAEL CI 22. Name a 8900 I not enter the mo	EMETE and Address REIST de of dyin	ERY 08	SOL L IN ROA	EVINSO D - PI	N & E KESVI t.	BROS.	Approximate Interval Beh Onset and I
by Physician/Medical Examiner		4 Donation 5 Other (Special Control of Contr	ansee Additions that caused yone cause on each line.  a. Precuring Due to (or as b. Due to (or as c. Due to (or as d. d. 23c. If yes, outcome 1 Live bith 4 Pregnant at 9 Unknown	d the death. Do ne.	SRAEL CE 22. Name a 8900 I not enter the mo	EMETE nd Addres REIST de of dyin	ERY 08 ss of Facility FERSTOW ag, such as car an in Part I.	SOL L IN ROA rdiac or res	EVINSO D - PI piratory arres	N & E KESV I t.	Date of do	Approximate Interval Between Day
Completed by Physician/Medical Examiner		4 Donation 5 Other (Special Signature of Funeral Service Lice Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 9 Unknown  Part II. Other significant conditions  Demantia, Pance	mplications that caused one cause of yone cause on each life.  a	d the death. Do ne.	SRAEL CE 22. Name a 8900 I not enter the mo	EMETE  nd Addres  REIST  de of dyin  pregnancy  pecify)  cause giv	ERY 08 ss of Facility FERSTOW ag, such as car an in Part I.	SOL LIN ROA	EVINSO  D − PI  piratory arres  23e. Did toba  1 □ Yes  24a. Was an autopsy performer	23d. I.	Date of domonth ontribute	Approximate Interval Bet Onset and I
o Be Completed by Physician/Medical Examiner	F	4 Donation 5 Other (Special Signature of Funeral Service Lice 123a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flag and flag is a final state cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	mplications that caused one cause on each limber of contract of the contract o	BNAI I  d the death. Do ne.  WWW.  a consequence a consequence a consequence a consequence c of pregnancy 2   Fetal death t time of death but not resulting in	SRAEL CE 22. Name a 8900 F not enter the modern of the control of	emetre nd Address REIST de of dyin	ERY 08 ss of Facility FERSTOW ag, such as car en in Part I.	SOL LIN ROArdiac or res	23e. Did toba  1 Yes  24a. Was an autopsy performed yes 25 yeck only one	23d. I.	Date of dominate of the prior to death?	elivery Day  to the cause of deprobably 4 autopsy findings autopsy findings are completion of cause 2 No
Be Completed by Physician/Medical Examiner		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if a second consistence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 Who 9 □ Unknown  Part II. Other significant conditions  Demantia, Partice  25. Was case referred to medical	pnplications that caused yone cause on each life.  a. Pneum Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 go Unknown contributing to death by the popular of the popular on the popular on the popular of the	BNAI I  d the death. Do ine.  WWW. a consequence a consequence a consequence a consequence c of pregnancy 2   Fetal death t time of death out not resulting in typertens.	SRAEL CF 22. Name a 8900 F not enter the modern of the control of	oregnancy pecify)  Cause give y chair	ERY 08 ss of Facility FERSTOW ag, such as car on in Part I. Fron.  26. Place of	SOL LIN ROArdiac or res	23e. Did toba  1 Yes  24a. Was an autopsy 11 Yes 25	23d. I.  23d. I.  23d. I.  23d. I.  23d. I.  24l	Date of domonth on tribute of a prior to death?	elivery Day  to the cause of deprobably 4 autopsy findings autopsy findings are completion of cause 2 No

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29d. Date signed (Month, Day, Year) 08/14/2000

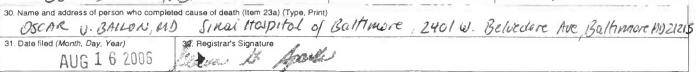
29b. Signature and title of certifier

Oscor Bacter, Mi

RES 000

State

AUG 1 6 2006



Registrar

State of Maryland / Department of Health and Mental Hygien [ ] - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 15, 2006 6:55 A Catherine M. Fuchs /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Parkville Baltimore 8805 Alnwick Road 8. Date of Birth (Month, Day, Year) Cont. 19,1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🛛 F 88 213-03-1439 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a Medical Exercities materials 1 ☐ Yes 2 No Parkville Maryland Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 u.s.A. 8805 Alnwick Road permit. Pages 1 and 2 should be filled within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or incorporate. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Agnes S. Machacek Paul Vanek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8805 Alnwick Road, Parkville, MD Anna Marie Fuchs (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/18/2006 Baltimore, Maryland Most Holy Redeemer ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Faryeral Service Lineansee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 yr Atherosclerotic cardiovascular **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ģ 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by aortic ancurysm 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Peripheral artery page 2 performed? 1 ☐ Yes 2 ☑ No Hypertension 1 Yes 2 No After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) Medical Certification; To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOD18410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Falls Rd, Lutherville, MP M Mumford M.P 10755 Laura 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3. Time of Death

Birthplace (State or Foreign Country)

African-

American

System

10d. Inside City Limits

1 Tyes 2 TNo

MD 21133

Approximate Interval Between Onset and Death

unknown

Unknown

Unkn mn

Year

Maryland

2:05AM

Year

2006

n/a

USA

attending physician for use as the buria been signed by should be detac has filled in by the funeral director. After t

Be

Certification: To

Medicai

RANKLIN, MARCARET

or Attending Physicien:

death.

To the Hospital within 24 hours a To the Funerel Completely filled

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

25. Was case referred to medical examiner?

1 🗌 Yes

27. Manne of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

2 No

5 Pending

investigation

6 Could not be determined

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4□Pregnant at time of death

2 ER/Outpatient

28b. Time of

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 impatient

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy

26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes

28a. Date of Injury (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 PNo

29c. License number 29b. Signature and title of certifier P-18613 , M.D.

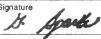
29d. Date signed (Month, Day, Year) AUGUST, 14, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUHAMMAD SAIM, M.D. 9005. CATON AVE. BALTIMORE, MD - 21229,

State Registrar

32 Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 6 2006



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		1	For State Registrar	State of M	arylan			nt of He te of D		Mer		ienę 🛭 🕻 19g. No.	16	25785
			Decedent's Name (First, Middle, Las	t)			,		,		Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		MIIDA.	eD_		G	1 F	7NC	4		ugust			9:35 A M
	Examin		4a. Facility Name (If not institution, give	street and number)					ocation of Dea	ith		4c. County		
		*	14 Proctor Avenue 5. Social Security Number 6. Se		o (In ure	last birthday)		en Bur	nie If Under 24 Hr	S. A	Date of Birth	Anne		indel place (State or Foreign
	Funeral Director			M 2 □ F   '. N	97	Yrs.	Months		Hours Mir	Se	pt. 19	Year 1908	Penr	isylvania
P.			Usual Residence of Decedent											
	anylan show		10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the Marylar a or 28a-f show	Director		rundel	G.	len Bur	_	C- O-d-			1	Og. Citizen of W	lhat Cau	
	with t	5	10e. Street and Number					ip Code 21060			"	United		
	ne 23a	Funerai	14 Proctor Avenue	12. Was Decedent		.S. 13. \			panic Origin? ( , Mexican, Pue	Specify	Yes or No-	14. Race	- Ameri	can Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kher than "natural", or iteme 23a or 28a-f show wher than "natural", or items the rediffed at ent, the Medical Exactings the profiled at	፩	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 X  If Yes, Give  Year or Dates:				ecify Cuban 2∑ No	Specify:	rto Hica	in, etc.)	Specify.	k, White, Wh	nite
2-0	72 hours "natural", dical Exe	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	dent's Us	ual Occupat	tion uring most of w	orkina		16b. Kind of Bu	siness/lr	ndustry
21	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired)		57.Kii 19				CI.
121	lled w tygier her th		12 17. Father's Name (First, Middle, Last)			F	eta:	ll Cle		ama /F	irst Middle A	Depart Maiden Sumami		Stores
Maryland	d 2 should be filed within 72 ho th and Mental Hygiene. ?? is marked other than "natur traumatic event, the Medical	o Be	John Hess						Bertha			naiddir Odiniani	0)	
Ž	shoul nd Me mark	ဥ	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addre	ss (Street ar				City or Town,	State, Zij	p Code)
	Health a tem 27 is		Jeff C. Graham, C	Frandson		225	Slade	e Mill	Road,	Val	encia,	PA 160	)59	
Baltimore,	of Healt of Healt fitem 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. I	Place of Dispo cemetery, crer	sition (N	ame of r other place	)	Date		20c. Location -	City or T	own, State
Ë	permit. Pages Department of I Important: If Ite eny injury or of once.		4 ☐ Donation 5 ☐ Other (Specification )	y)	Ser	wickley								Pennsylvania
Ball			21. Signature of Fundral Service Licen		0111	_						Cole F ey, PA 1		ral Home 3
3			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	ne.		_	ode of dying	, such as cardi	ac or re	spiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. 0	2m	en/	(d							
	/Medical Examiner		7000tting in obusin,	Due to (or as	a consec	uence of):								
*		er	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consec	quence of):								
1	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
o o	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consec	quence of):							-	
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9		0	IF FEMALE:	23c. If yes, outcome	of pregn	ancv						23d. Date	o of dolin	von.
Box	eath certif attending for use a	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Feta	al death 3	Ectopic Other	pregnancy (specify)				Z3d. Dati		Day Year
P.O.	that the de ed by the detached	nysi	1 Yes 2 DV6 9 Unknown	9□ Unknown				-,,,						
Division of Vital Records, P	88 G 99	d by Physician/M	Part II. Dther significant conditions of	contributing to death t	out not res	sulting in the u	nderlying	g cause give	n in Part I.					the cause of death? bably 4 Donknown
00	w requires been si should!	Completed									24a. Was a	n 24b. V	Vere aut	opsy findings available
Re	The lav	E O									autops perform		rior to co death?	ompletion of cause of
ita	ysicien: The l s certificete ha director, page	BeC	25. Was case referred to medical examiner?						26. Place of D	eath C		T. T		
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o uc	ding P	ino]	27. Mann Death Natural 5 Pending	28a. Date of Injui	ury ay Year)	28b. Time o Injury	f M	28c, Injury Work	at ? ′es 2 ∐No	280	. Describe ho	ow injury occurr	ed	
isic	or Attendation of the football	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	B ORD Blace of In	íurv - At h	ome farm str				28f.	Location (St	reet and Numb	er or Rui	ral Route Number,
Οį	s after s after si Dire ed in by	Certification:	4 Homicide determined	building, e	tc. (Speci	fy)					City or Towr	n, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier Contifying Ph (Check only 2 Medical Examone)	nysician: To the best miner: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurre vestigati	ed at the time on, in my op	e, date and pla inion, death oc	ce, and curred	due to the ca at the time, d	ause(s) and ma ate and place, a	nner as	stated. to the cause(s)
	To th Withir To th comp	W	29b. Signature and title of certifier	1000			2	9c. License		0		9d. Date signed		
	/		Mayer	12 16Ca	u	ME	) 2	02	173	0	1	14941	1/	5,2006
	5		30. Name and address of person who	orbaty	de	0 1	Print)	Aqu	auhort	R	J. 61	en Bu	uni E	15,2006 1021061
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 6 2	2006 32. Hegist	rar's Sign	ature	204	وم						

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		•	For State Registrar	,	Ce	rtificate	of Death		Reg. No.	Ub	25786
	Physici	an	Decedent's Name (First, Middle, Last)			FAF	~	2. Date of De. Month	Day	Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give s	terest and a series			own, or Location of Death	Augusi	4c. County	006	23=48 M
	Examin		UPPER CHESAPETICE A		ITEM		ELAIR	1		1 00	~()
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1		8. Date of Bird			
	Director		2.0 00 00.0	1M 2□F 52	Yrs.	IVIOITIIS	Day's Flours Will.	8. Date of Bin (Month, Da Jan. 8	, 1954	Mari	lace (State or Foreign try) YLand
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				11	0d. Inside City Limits
	r 28a-f ehow	to	Maryland Harford	:	F	allsto	n				1 ☐ Yes 2 No
	death with the Maryland me 23s or 28s-f ehow rmust be notified at	Director	10e. Street and Number			10f. Zip C			10g. Citizen of V		try?
	e 23a	ral	2037 Durham Road	10 Mas Dandart Funt in I	10 12	Was Casadas	21047	poof. Voc or No		C.A.	an Indian
- 10		Funeral	11. Marital Status 1 ☐ Never Married 2 🕱 Married	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			nt of Hispanic Origin? (S) y Cuban, Mexican, Puerti	o Rican, etc.)	Blac	ck, White,	etc.
<u> </u>	72 hours after natural', or Ite	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🎉	No Specify:		Specify	r Whi	te
5-0-5	72 h	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece (Give	dent's Usual of kind of work	Occupation done during most of work retired)	king	16b. Kind of Bi	usiness/Inc	lustry
<u>~~~</u>	within ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		rinten			Constr	uctic	on
34 Jan	2 should be filed with and Mental Hygiene le marked other the aumatic event, ins.	Be C	17. Father's Name (First, Middle, Last)		· · · · ·		18. Mother's Nam	ne (First, Middle,	Maiden Suman	10)	
a de	Menta Menta arked artic ev	To B	William Patrick (	Faff, Sr.			Toya	Stoke	rl		
8/// 000 33 4 $8$ Baltimore, Maryland 212	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relationship (Ty		1		Street and Number or Ru				Code)
2	1 and Health em 27		Mary Jo Gaff  20a. Method of Disposition	(wife)	Place of Disponentery, cre		m Road, Fal	CSLON, N	1D 2104 20c. Location -		wn, State
	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Items or other tra		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)				erplace) Cemetery 8/	18/2006		•	
	mit. F partmi sortar / Injur		21. Signature of Fyrigan Service License		2	2. Name and	Address of Facility Sc	himunek	Funeral	Home	
000	e d e d		Joga (Miniau)	ds		9705 B	elair Rd., 1	Baltimor	Le, MD 2	1236	
			23a Part Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the dea ne cause on each line.	ith. Do not en	ter the mode	of dying, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1	4 3 C U	0					
	Examiner			Due to (or as a conse	quence of):						
	D. =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter bridging Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):						
5	and Arrans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	guanca of):						
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(LD)	ifficate g phy: as the	edlo							-		
T X	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic preg	gnancy			te of delive	•
0.0	the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5[	Other (spec	cify)		Mic	4101	Day Year
H WILL arm MS0 vision of Vital Records, P.O.	that the died by the detached	/Ph	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	inderlying cau	use given in Part I.	23e. Did t	obacco use cont	tribute to th	ne cause of death?
rds	w requires that s been signed b should be det	ed by						1 🗆	Yes 2 No	3 ☐ Prob	ably 4 Unknown
≥ 8	ne law re has bee ge 2 sho	Completed						24a. Was	an 24b.	Were auto	psy findings available mpletion of cause of
2 E		E O						perfo	rmed?	death? 1 🗌 Yes	_
	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			26. Place of Dea	ath Check only	one)		
> 5	S D	5	1 ☑ Yes 2 ☐ No  27. Manner of Death	1   Inpatient 2	28b. Time o			lome 5 Resi	dence 6 Oth		1)
On I	nding ith: :: Afte e fune	atlor	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	c. Injury at Work? 1 ☐ Yes 2 ☐ No				
Z is	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st	reet, factory,	office	28f. Location ( City or To	Street and Numb wn, State)	er or Rura	I Route Number,
(P	ortel o urs aft eral DI		450 451								
0	To the Hospitel or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sicien: To the best of my kr ner: On the basis of examin and manner stated.	lowledge, dear lation and/or in	th occurred at nvestigation, in	the time, date and place n my opinion, death occu	rred at the time,	date and place,	and due to	ated. the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	. 1		29c. 1	License number		29d. Date signe	d (Month.	Day, Year)
	1		Manush ~	4-00 M-00	ME		D 21809		Augus	17 13	2006
	9		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type		IMONIC	1 . 4 . 4 .			
	St	ate	31. Date filed (Month, Day, Year)	3. Registrar's Sign		- 7	MONIC	JAJ W	0 210	1 7	
	Regist		AUG 1 6 2006	fillower &	X An	Pare					

	1 - For Stete Registrar				artment of H			Reg. No.		3. Time of Death	
ician dical							2. Date of De Month August	15 2	Day Year		
niner	4a. Facility Name (If not institution Continuum Car	n, give street and nu e At Syke	At Sykesville			Location of De		Carro		511	
al or	5. Social Security Number 213–28–7806	6. Sex 1 X M 2 □ F	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hours M	in. B. Date of Bir (Month, Date of Bir Dec 8	1928	9. Birthp Coun MD	lace (State or Foreig try)	
ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Sykesville							1,	0d. Inside City Limit		
Funeral Director	10e. Street and Number 1830A Vincenza Drive							10g. Citizen o	og. Citizen of What Country?		
DDG8.  To Be Completed by Funeral Director		1. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces? 1 1 2 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			1051 If Yes, specify Cuban, Mexican				14. Race - American Indian, Black, White, etc. Specify: white		
Completed		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5			16a. Decedent's Usual Occupation (Give kind of work done during most of ville. DO NOT use retired)  Welder			ing welding			
To Be Co							Name (First, Middle, Maiden Sumame) e Germack				
	19a. Informant's Name/Relation	mant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town  1830A Vincenza Dr., Sykesville, Md 2							Code)		
	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)						Date .9-06	20c. Location - City or Town, State Randallstown, Md			
SUCE	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Char P.O. Box 195 Sykesville, Md 21784									Chape!	
al er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):							4	Approximate Interval Between Onset and Death		
dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	b.  Due to (or as a consequence of):  d.								
Physician/Med		1 ☐ Live 4 ☐ Pre	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year		
۾	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📆 0 3 ☐ Probably 4 ☐ Unknown			
Completed	autopsy prior to performed? death							b. Were auto prior to co death? 1  Yes	psy findings availab mpletion of cause of 2 No		
To Be Compl	25. Was case referred to medic examiner?	26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: Nursing Home 5 Residence 6 Other (Specify)								iz)	
ation: To		28a. Dat	28a. Date of Injury (Month, Day Year)		28b. Time of 28c. Injury W		28d. Describe how injury occurred			,,	
Medical Certification:	3 Suicide 6 Coul 4 Homicide dete	mined 200. Fla	ce of Injury - At Iding, etc. <i>(Spe</i> c	r - At home, farm, street, factory, office (Specify)			28f. Location (Street and Number or Aural Acute Numb City or Town, State)			ul Route Number,	
dical (	29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month) Date (Month) Dat								tated. the cause(s)		
M	29b. Signature and title of certifier  29c. License number						137	29d. Date sig	ined (Month)	Day, Year) (	
	30. Name and address of person	n who complete ca	use of death (Ite	em 23a) (Type	Print)	-		- 1	1	MO 2115	

DHMH 17 Rev 1/2001

Registrar

AUGUST

ORIGINAL

AUG 1 6 2006

1

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1 Decedent's Name (First, Middle, Last) Physician/ Month 0810 hrs August 13, 2006 **Medical Examiner** Howard Cecelia Dolores 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 3030 Poplar Terrace If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Days Months Hours Min Director Country) MD 50 м 🗶 15 212-56-7086 56 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 'n 10a. State 10b County 1 X Yes 2 No 28a-f show items 23a or 28a-f shoust be notified at once. Baltimore NA death with the Maryland MDDirector 10g Citizen of What Country 10f. Zip Code 10e. Street and Number 21216 U.S.A. 4009 Bateman Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 11. Marital Status must be White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Black Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygener and said: If item 27 is marked other than "natural", o on other traumatic event, the Medical Examiner in or other traumatic event, the Medical Examiner in Divorced Give Year Yes 2 X No specify Specify 3 Widowed ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Baltimore, MD 21215-0036 CPA Self Employed 4yrs 12th grade 17 Father's Name (First, Middle, Last 18 Mother's Name (First, Middle, Maiden Surname) Novella Jennings Be David H. Howard 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 4009 Bateman Ave, Baltimore, Md Novella Howard-Mother 21216 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: I injury or othe 8/19/06 Baltimore Co, Woodlawn Aonation 5 Other Specify. 22. Name and Address of Facility
March F/H West atur of Funeral Service License 21215 4300 Wabash Ave, Baltimore,  $_{
m Md}$ disease, or complications that ca sed the death. Do not enter Approximate Interval I. Enter th **Physician** Between Onset and re. List only one cause on each line. /Medical Narcotic (Morphine) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transi Physician/Medical X UNPENDED AMENDED item#23a,PII,27,28a-f,perME,g858,8/31/06 TT Box 68760. 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown detached for Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. icate has been signed by page 2 should be detach Š 1 Yes 2 V No 3 Probably 4 Unknown Cocaine use Completed 24b. Were autopsy findings available 24a. Was an this certificate has been autopsy performed? prior to completion of cause of death? 1 🗸 Yes ✓ Yes 2 To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical 26 Place of Death (Check only one) funeral director, Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 🗸 Yes 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? After Manner of Death 28b. Time of Injury Certification: a 24 hours arter war Funeral Director: A Natural 1 Yes 2 X No Fnd 8/13/2006 Fnd 8:00 am Accident 2 Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3030 Poplar Terrace Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined (Specify) found: private dwelling <u>Baltimore</u> Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert O.C.M.E August 13, 2006 pleted cause of death (Item 23a) 30. Name and address of person who com 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State AUG 1 6 2006 Registrar

**ORIGINAL** 

#### 06-05940 Josephine Harding

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certifica	ate of Death	Reg.	No 211	6 2570			
Physici		Decedent's Name (First, Middle, Las	,		Date of Death     Month     Date	Day Year	3. Time of Death			
Medical Exam	iner	Josephine Jolie  4a. Facility Name (if not institution, giv		4b. City, Town, or Location of Deat	Month Day August 10, 2		1810 hrs			
and the second		Howard County General H	· ·	Colimbia	п	4c. County of Death Howard				
Funeral		Social Security Number     6 Security Number	x 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth(	MM/DD/YYYY) <sup>g</sup> Birtl	nplace (State or			
Director		215 75 7400	M 2 E	Yrs, 4 Days Hours Min		Foreign Cou	n Intry) MD			
		215-75-7488 1 L Usual Residence of Decedent	- XX / 10/	**************************************	104/06/0	6	TATA			
v any		10a State 10b. County	10c. City, Town	or Location			10d. Inside City Limits			
aryland 8a-f show any at once.	or	MD Howard	Co. Ellico	ott City			1 Yes 2 No			
Mary 28a-	Director	10e. Street and Number	N + - C	10f. Zip Code	10g.	Citizen of What Coun	try?			
ith the Maryland 23a or 28a-f sho notified at once.		3129 Wheaton Way		21043		USA				
ath wi tems st be	Funeral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No- c Rican, etc.)	14. Race - Americ White, etc.	an Indian, Black,			
ierde ", or i			1 Yes 2 No	1 Yes 2 No specify		Specify: 131 a.				
ours af	d by	15. Decedent's Education (Specify or	or Dates: Ily highest grade completed) 16a. [	Decedent's Usual Occupation (Give kind of		Specify Bla 8b. Kind of Business/Ir				
5 72 hc m "ns ral Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NOT use rel	ired)					
0036 within 72 jene er than '	m d	n/a	n/a	n/a		n/a				
15-C filed v Hygi d oth d oth		17. Father's Name (First, Middle, Last)		18.Mother's Nam	e (First, Middle, Maid	den Surname)				
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	To Be	Christopher Bri 19a. Informant's Name/Relationship (T	<del></del>	. Mailing Address (Street and Number or		0.1	7: 0 1			
MD 2  td 2 should hand No 27 is manatic										
- P = E = I		20a. Method of Disposition	20b. Place of	29 Wheaton Way Apt.  f Disposition (Name of cemetery,	Date 20	<u> Ott City                                 </u>	MD 21043 Town, State			
nore ages 1 nt of F nt: If i		1 X Burial 2 Cremation 3	Removal from State cremato	ory or other place)	1	lkridge, M				
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite	1	Donation 5 Other Specify: 21 Signature of Funeral Service Licen								
inj. In De R		1 brilding		2 Name and Address of Facility L. Kaufman Funeral 7250 Washington Blvd.	Home at Me	adowridge Mar D 21075	morial Park			
Physician		23a Part I. Enter the disease comp	ications that caused the death. Do not	t enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner	Examiner Immediate Cause (Final disease a Sudden unexplained death in infancy									
		or condition resulting in death)	Due to (or as a consequence of):							
	ē		Due to (or as a consequence of):							
	盲	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):								
ecuted and transit		events resulting in death) Last	Jue to (or as a consequence of):							
0, be execut sician and	Physician/Medical	X UNPENDED	AMENDED #00 07	1.00 5 NE 000 10 lo lo						
760, icate be expensed in the purial	ğ.	IF FEMALE:	23c. If yes, outcome of pregnancy	/,28a-f,perME,g860,10/2/0		23d Date of delivery	<del>-</del>			
687 ertific ding p	jan/	23b. Was decedent pregnant in the past 12 months?		Fetal death 3 Ectopic pregna		Month Da	ay Year			
Box 68760 e death certificate be the attending physical of for use as the bu	/sic	1 Yes 2 V No 9 Unknown	4 Pregnant at time of death 5	Other (Specify)						
P.O. Box 687 s that the death certific gned by the attending is e detached for use as it		Part II. Other significant conditions		in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?			
ires that the signed by	g P				1 Yes 2	2 No 3 Proba	ibly 4 🗸 Unknown			
ords, w requir s been s should	Completed			,	24a Was an		ppsy findings available			
SCO te law te has	Ē		<del></del>		autopsy	d? death?	mpletion of cause of			
tal Recian: The certificate		25 Was case referred to medical		26 Place of Death (Check	1 Yes 2	No 1 Yes	2 No			
Vital I ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No	ospital. 1 Inpatient 2 ✔ ER/Ou	Othor	···	sidence 6 Other:				
1 of Virting Physical After this funeral direction		27 Manner of Death	28a. Date of Injury (Month, Day,Year) 28b. T	ime of Injury 28c. Injury at Work?	28d. Describe how	injury occurred				
ision Attendi rr death. rector: /	랿	Natural 5 Pending Accident Investigation	Fnd 8/10/2006 Fnd	. 5:30 pm 1 Yes 2 X No	unk					
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X Could not b	28e. Place of Injury - At home, far	m, street, factory, office building, etc.	28f. Location (Street	et and Number or Rura 3129 Wheaton Ity, MD	al Route Number, City			
Divis  Di	ë	4 Homicide determined	TOGIN III I							
# 22 H				th occurred at the time, date and place, and vestigation, in my opinion, death occurred a						
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated	29c. License number		9d. Date signed (Mont.				
_		Marial 1	LOODAIN	O.C.M.E.	1.	ugust 11, 2006	ii, Day, rear)			
	+	30. Name and address of person who o	ompleted cause of death (Item 220)							
	-			Penn Street, Baltimore, MD 2120	1					
St	ate	31 Date filed (Month, Day, Year)	32. Registrar's Signature	9 - 4						
Regist	trar	AUG 1 6 20	16 Regers of	Coaches						

Ishmael Montay Hartgrove-Bey

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 2579

		- For State egistrar			Certific	cate of	Death			F	Reg. No.	[	JUI	0 2.019
Physician ledical Examine	1	1. Decedent's Name (First, Middle,Last)  ISHMAEL MONTAY HARTGROVE-BEY								Date of De Month August 4	Day	Year		3. Time of Death 1347 hrs
	4	la. Facility Name (if not institution Bon Secour Hospital					b. City, Town, Baltimore		of Death	-	40	County o		
Funeral Director		5. Social Security Number 219-92-2883	6 Sex	7. Age (Ir	yrs. last bi	rthday) Yrs	If Under 1 Y Months D	ear If Und	der 24Hrs.	8 Date of B	•	/DD/YYYY)	9 Birth	nplace (State or nntry) MARYLAND
; any	-	Jsual Residence of Decedent  10a. State 10b County	b	100	c. City, Tow	n or Location	on						- 1	10d Inside City Limits
faryland 28a-f show	<u>.</u>	MARYLAND N/	Α			BALT					40~ Cit	ran of M/h		1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once		10e Street and Number 2314 EDMONDSO	N AVENUE				10f. Zip Code			10g Citizen of What Cour				uy e
or items 23:	nuera	11. Marital Status	12. Was De Armed F				Decedent of es, specify Cul	Hispanic O				14 Race - American Indian, Black, White, etc. AFRICAN		
s after c	<u></u>	3 Widowed 4 Div 15. Decedent's Education (Spec	orced If Yes, Give Ye or Dates.	ear			Yes 2 X			rk dono	16h	Specify Kind of Bus	Al	MERICAN
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-f She tranmatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) 9th grade		(1-4 or 5+)			st of working					PRIVA		idusity
215-0036 be filed within 7 ntal Hygiene. Red other than ent, the Medica		17. Father's Name (First, Middle,	Last)			211(11)12	II(DI(	18 Moth	er's Name (	First, Middle,				
2121 2121 Suld be fi Mental I marked ic event,	o ne	TYRONE M HART  19a Informant's Name/Relations		ζ	1	9b Mailing	Address (St			SIMMS			State	Zin Code)
MD 2 should alth and M 27 is m 27 is m	-	Cynthia Burman												3 21206 Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmitte event, the Medical Communic event, the Medical Communic event, the Medical Communic event, the Medical Communic event, the Medical Communic event, the Medical Communical  - 1	20a Method of Disposition  1 X Burial 2 Cremation		from State		of Disposi atory or oth		cemetery,		Date	20c.	Location -	City or	Town, State	
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Domation 5 Other Sp 21. Signature of Mineral Service			KING		RIAL PA			6-06				MARYLAND
Balti permit. Departm Imports injury o	V	Dalkay Ci				1 13	206 W N	ORTH	AVENU	E				ME P.A.
Physician /Medical	1	31. Part I. Enter the disease or failure. List only one cause	on each line					ng, such as	cardiac or	respiratory a	rrest, sh	ock, or hea	rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final Insease or condition resulting in death)	a. Hyper Due to (or as			disea	se							Death
	ا <u>ء</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as	a consequ	ence of):									
ed	۱ء	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of).									
760, icate be executed physician and the burial - transit	n/Medical	X UNPENDED	AMENDED	item	#23a,PI	I,27,p	erME,g85	8,8/19	/06 TT					
<b>∞</b> ≒ ≘ s l :	sician/Me	IF FEMALE. (3b. Was decedent pregnant in the past 12 months?	1 Live	birth gnant at tim	of pregnanc	2 Fe	al death	3 Ector	pic pregnan	су	23	Month		ay <b>Y</b> ear
b. Bc the dea	Physicia	Part II. Other significant condit	9 OIIK		ut not result	ing in the u	nderlying cau	se given in l	Part I.	23e. Did	tobacco	use contri	bute to t	he cause of death?
rires that the death cert signed by the attendir		Fatty metamorph	-							1Y	es 2	No 3	Prob	ably 4 V Unknown
cords law requ has been 2 should	Completed by										opsy formed?	þ		opsy findings available ompletion of cause of S
1 of Vital Recting Physician: The After this certificate funeral director, page	Be -	25. Was case referred to medica examiner?	Hospital:					Other	h (Check or					
of Vir	의	1 Yes 2 No 27. Manner of Death	28a Dat	e of Injury	2 🗸 ER/	Outpatient  Time of I		njury at Wo		Home 5 28d Describe		ence 6 jury occurre	Other:	
ion C tending leath tor: Af the fun	ation	1 X Natural 5 Pen 2 Accident Inve		th, Day,Year)			1	Yes 2	No					
Division pital or Attene ours after death ceral Director: filled in by the	The street of th										ral Route Number, City			
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the basis aminer:On the basis	s of examin	nowledge, d ation and/o	leath occur r investigat	red at the time ion, in my opir	, date and p lion, death	place, and o occurred at	due to the ca the time, dat	use(s) a e and pl	nd manner lace, and d	as start ue to the	ed. e cause(s)
F % F 8	ž	29b. Signature and title of certification of the Country of the Co	er Mch-	Pa	lloh	٠.		ense numbe	er		- 1	Date signe gust 5, 2		nth, Day, Year)
\$		30. Name and address of persor Patricia Aronica-Polla			th (Item 23a dical Exa		111 Penn	Street, E	Baltimore	, <b>M</b> D 212	01			
Sta Registr		31 Date filed (Month, Day, Year)	2006	Registrar's	Signature	Loon	K)	-						
DHMH 17 Rev 1/200	_				0	RIGINA								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13, 2006 5:39 A M August Hilda Agnes Hanna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4009 Wilke Avenue N/ABaltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 12 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year) 920 1 ☐ M 2 💢 F Vrs 218-03-2845 Director 86 Maruland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore Maryland N/A 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 4009 Wilke Avenue 21206 u. s. A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I hoperant: If tem 27 is marked other then "natural", or the any injury or other traumatic event 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wenceslaus Heil Amelia Conrad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Stanley (Daughter 4009 Wilke Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 08/16/2006 Baltimore Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medicai JF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 4☐Pregnant at time of death ☐Yes 2 HNG should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed 1 🗌 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bastern Av, Balt 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink

Manyland / Department of Health and Mental Hydiene

Jemone Jackson	1	State of Maryland / - For State, Registrar		ate of Death	u Mentai ii		200	6 2579		
Physiciai Medical Examin	1.6	1. Decedent's Name (First, Middle,Last)  Demone		Jackson	-	2. Date of Death Month June 24, 20		3. Time of Death 0319 hrs		
		4a. Facility Name (if not institution, give street and number) 1000 block of Hillman Court		4b. City, Town, or Baltimore	Location of Death		4c. County of Death			
Funeral Director		217-94-4252 1XM 2 F	In yrs. last birtl	Months Day:		-	(MM/DD/YYYY) 9. 8ird Foreig Cou			
Maryland 28a-f show any 1 at once.	ľ	Usual Residence of Decedent   10a. State   10b. County   1   NA     NA	0c. City, Town	or Location altimore				10d. Inside City Limits 1 X Yes 2 No		
ith the Maryl  23a or 28a-	Dire	10e Street and Number 4843 Greencrest Rd.		10f. Zip Code 2120	6	100	g. Citizen of What Cour USA	ntry?		
ter death wi ", or items er must be	by Funeral	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 X No specify:			op cony.	lack		
5-0036 led within 72 hours af Hygien of the man "natural the Medical Examin	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+ 9th grade	)	Decedent's Usual Occupat during most of working life Laborer			16b. Kind of Business/I	ndustry		
21215-0036 ould be fited within 7 a marked other than ite event, the Medica	8	17. Father's Name (First, Middle, Last) John	Jackso	on	18.Mother's Name Doris		Will			
MD 21  d 2 should d 2 should lth and Me n 27 is ma ummatic ev		19a. Informant's Name/Relationship (Type, Print)  Doris Tinsley Mother		Mailing Address (Stree 4943 Greenc	rest Rd.	, Baltim	ore, Md.	21206		
Baltimore, MD 21215 permit Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other tranmaric event, the		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  King Mem. Park  6					20c. Location - City or Randallsto	own, Md.		
Balt permit. Depart Import injury		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Baltimore, Md. 2120  March F.H. East 1101 E. North Ave.								
Physician /Medical Examiner	1	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Shotgun Wounds Due to (or as a consequence)	i	at enter the mode of dying,	such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death		
		Sequentially list conditions, if any, leading to immediate  b								
nsit A	E	cause. Enter Underlying Cause (c. issesse of highry that initiated events resulting in death). Last Due to (or as a consequence).	uence of);				·			
760, icate be executed physician and the burial - transit	edical	d.  UNPENDED AMENDED								
ox 68  Ith certif  Ittending  or use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome 1 Live birth 4 Pregnant at ti	. 2		Ectopic pregna	incy	23d. Date of delivery  Month D	ray Year		
s, P.O. Bc	Š	Part II. Other significant conditions contributing to death I	out not resulting	g in the underlying cause ξ	given ın Part I.	_	acco use contribute to t			
Division of Vital Records, rate death.  Is after death.  The law require an arter death.  The law required by the form of the law been is led in by the funeral director, page 2 should be in the funeral director.	Completed					24a. Was ar autopsy perform 1 Ves 2	y prior to coned? death?	copsy findings available completion of cause of complex s 2 No		
Vital   ysician: his certifi director.	o Be (	25. Was case referred to medical examiner?  Hospital: 1 Inpatien:	2 ER/O		of Death (Check	<del></del>	tesidence 6 🗸 Other	Scene		
ion of Vi tending Physi eath. toer: After this	$\vdash$	27. Manner of Death  Natural  Accident  No  Pending  No  Pending  No  No  No  No  No  No  No  No  No  N	28b. 3		ry at Work?		w injury occurred	772		
Division At the control of the contr	Certification	3 Suicide 6 Could not be determined (Specify) Side	walk	rm, street, factory, office b		or Town, Sta 1000 block of	f Hillman Court, B	altimore, MD		
To the Hospital within 24 hours To the Funeral completely filled	Medical	Check only one) 2 Medical Examiner: On the best of my one) and manner stated.								
F % F %	Me	29b. Signature and title of certifier  Favorite Bouthall, MO		29c. Licens O.C.I			29d. Date signed <i>(Mon</i>	th, Day, Year)		
\		30. Name and address of person who completed cause of de Pamela Southall, MD Assistant Medical	,	111 Penn Street, E	Baltimore, MD	21201				
Sta Registr	-	31. Date filed (Month, Day, Year) AUG 1 6 2006 32. Registrary	8.	lineally		*				
DHMH 17 Rev 1/200			ef	IGINAL						

			State of Maryland / Department of Health and 1- State Registrar Certificate of Death	d Men		ene 200	6 25794					
	Physici	an	Decedent's Name (First, Middle, Last)  TAMALLY COLLOWING  TOWNS COLLO	N	Date of Death	Day Yea	3. Time of Death					
	/Medic	al	EMILY O.JONES  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		UG. 1	2 2006 4c. County of De						
	Examin	er	FUTURECARE - OLD COURT RANDALLSTO			BALTI	MORE					
	Funeral Director		217-34-5130 1 92 Yrs. 92 Yrs.	1 1 2 1 2	Pate of Birth Month, Day, 1	9. E	Birthplace (State or Foreign Country) IARYLAND					
	Maryland I-f ehow	tor	Usual Residence of Decedent  10a. State MD  10b. County N/A  10c. City, Town or Location BALTIMORE CITY				10d. Inside City Limits  Y☐ Yes 2☐ No					
	death with the Marylan ne 23a or 28a-f ehow mast be notified at	ai Director	10e. Street and Number 2208 N. ROSEDALE STREET 21216		100	g. Citizen <i>o</i> f What USA	Country?					
036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow Jical Examinational be notified at	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin?  If Yes, Give Yes, Give Yes are or Dates:	(Specify Jerto Rica	Yes or No- n, etc.)	14. Race - Ai Black, W Specify: E						
21215-0036	within 72 ho jiene. r than "natur the Madical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12TH  16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)  ### College (1-4or 5+) 4 YEARS  PROBATION OFFICE		В	ALTIMOR	RE CITY					
Maryland 2	id be filed ental Hyg kad othe ic event,	To Be C		•		aiden Sumame) CHARD						
	nd 2 should lith and Men 27 te marka r treumatic	W S	19a. Informant's Name/Relationship (Type, Print)  JERUSHA HAMLETT / SISTER  19b. Mailing Address (Street and Number or 3612 LATHAM RD.,			-						
Baltimore,	Pages 1 and nent of Healt ant: If item 2 arry or other		20a. Method of Disposition  MD Burial 2 Department of Department of Commeter, Crematory of other place)  ARBUTUS MEM. PK. 8	Date / 16/		Oc. Location - City ALTIMOR						
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1	HOWE HEIG	LL FU HTS A	NERAL H V, BALT	IOME 21207					
	Pnysician	234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inter the cause (final district condition resulting in death)  Due to (or as a consequence of):										
	/Medical Examiner		Due to (or as a consequence ot):									
/	scuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate autoe. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									
68760,	ficate be executed physician and s the burial-transit	edicai Ex	Due to (or as a consequence of):  d.									
Box (	ath certif ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year					
rds, P.O	w requires that tha de been signed by the a should be detached f	þ	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.				e to the cause of death?  Probably 4 Hoknown					
Division of Vital Records,	The law re- ate hes bee pege 2 sho	Completed		-	24a. Was an autopsy perform 1 Yes 2	prior						
Zi ta	sician: certific rector,	Be	25. Was case referred to medical examiner?  Hospital: Other Other									
on of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funarel Director: After this certificate hes completely filled in by the funeral director, page 2	ation; To	1   Yes 2   No.   1   Inpatient 2   ER/Outpatient 3   DOA   2   Nursin- 27. Manner of Death 1   Natural 5   Pending 2   Accident   Investigation   2   Accident   Nursin- 28a. Date of Injury (Month, Day Year)   28b. Time of Injury   Work?   M   1   Yes 2   No			ce 6 Other (S	ipecify)					
Divis	el or Attendi s after death. Il Director: A od in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. I	Location (Stre City or Town,	eet and Number or State)	Rural Route Number,					
	To the Hospitel or At within 24 hours after or To the Funarel Direct completely filled in by	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and play one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.	ace, and o	t the time, dat	e and place, and o	iue to the cause(s)					
)	To t withi To tl	Σ	29b. Signature and title of certifier  29c. License number	8	<u>29</u> 6	d. Date signed (Mo	onth, Day Year)  5 2000					
	£		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  C717 Park BEGHTS BYENUE	B	ALTIH	TORE, F	1 DRYLAND					
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				21215					
	Regist	ar	AUG 1 6 2006 Glosen & Sparke									

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			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment			and M		iene	06	25795
	Dhuoisi		1. Decedent's Name (First, Middle, Last)							2. Date of Death		Year	3. Time of Death
	Physici /Medio		FREDERICK KY	LE						AUG.	7	0,8,	14:00 M
	Examir	ner	4a. Facility Name (If not institution, give s					Location o			4c. County		
			JOHNS HOPKINS  5. Social Security Number 6. Sex		(In yrs. last birthday			MORE If Under				/A	- 10 10
П	Funeral Director			M 2□F	89 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 05/09/	Year) 1917	Cou	place (State or Foreign ntry) RGINIA
			Usual Residence of Decedent							03/03/	1217	V 11	KOINIA
	nylan how		10a. State 10b. County		10c. City, Town or L		атш	3.7					10d. Inside City Limits
	Ba-1 e	cto	MD N/A		BALTI	MORE	CIT	Y					1 XYes 2 No
	vith th	Funeral Director	10e. Street and Number	DO3.D		10f. Zip		225		10	)g. Citizen of \	Whal Cou	ntry?
	239	erai	467 ROUNDVIEW		iver in U.S. 12	Man Daned		225	-:-2 (C=-		USA	a Amad	
	item item	in in	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12, Was Decedent E Armed Forces? 1 ☐ Yes 2 2 N	ver in U.S.	If Yes, spec	ify Cubai	n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Blac	ck, White,	
980	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2X No	Specify:			Specify	,: BL	ACK
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow ha Madical Exercities reveal be natified at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usua kind of wor	l Occupa	ition	t of worki	ina	6b. Kind of B	usiness/Ir	dustry
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT us	e retired,	}	O WOIKI	,,,,	<b></b>	N. C.D.	
	filed w Hygier other th		2nd		TR	UCK D	KTA			(5: . A.: . v. A			ORTATION
Maryland	2 should be filed vand Mental Hygie le marked other raumatic event, III	To Be	17. Father's Name (First, Middle, Last)  CONLEY MAXWELL	,						e (First, Middle, M Y KYLE	alden Suman	ne)	
	5 = 2 T		19a. Informant's Name/Relationship (Type WALTER F. KYLE							SAN JC			
Baltimore,	permit. Pages 1 an Department of Hea Important: if item 's any injury or other once.		20a. Method of Disposition	amousl from State	20b. Place of Disp cemetery, cre	osition (Nam matory or ot	ne of ther place	9)	C	Date 2	20c. Location -	City or T	own, State
Ĕ	Pages ment of I ant: If its ury or o		YSwirial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	OLD TO	WN CE	Μ.		8/1	9/06	GALAX	, V	A
Salt	permit. Departm Importa any inju		21. Signature of all Service License	° OX A									E 21207
	205 4 0		23a. Part Epier the disease, or complic	11.11						IGHTS A		LTIM	ORE, MD
	Physician /Medical Examiner	Examiner	show, or heart falure. List only on Immediate Cadse (Final disease for Shotlition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):  etc a consequence of):  vienta	Mell.	1	di	Je s	aie			Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dicai Ex	d d	Due to (or as a	consequence of):	vden	C	Luca	204	Le.			
O. Box 6	The law requires that the death certificate be executed vie hes been signed by the attending physicien and page 2 should be detached for use as the burtal-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 (	⊒Ectopic pre ⊒ Other (spe					23d. Dai Mo	te of delive	ery Day Year
S, O,	ires that signed b	by Pi	Part II. Other significant conditions con	tributing to death bu	t not resulting in the t	ınderlying ca	iuse give	n in Part I.		23e. Did tob			ne cause of death?
0.0	requ	ete											
Rec	he lav	Completed								24a. Was an autopsy	,	Were auto prior to co death?	psy findings available mpletion of cause of
B	n: Th ficete or, pa	ပိ	25. Was case referred to medical								⊠No 1		2 No
₹	Physician: this certificant director,	8	examiner?	ospital:	nl 2 ER/Outpatie	nt 3 DO	Othe			Check only one		10	
ō	y Phy er this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day			Bc. Injury Work			me 5 Resider			y)
Ö	Attending r death. ector: Alter by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	м		? ′es 2 ∐ ñ	No				
Division of Vital Records,	Hospital or Attended to the control of the control	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory,	, office		1	28f. Location (Str City or Town,		er or Rura	I Route Number,
	To the Hospital or Attending Physician: The lawithin 24 hours effecteath. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2	edicai C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	sician: To the best of ter: On the basis of and manner sta	f my knowledge, dea examination and/or in ted.	th occurred a evestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ca ed at the time, da	use(s) and ma te and place,	inner as s and due to	tated. the cause(s)
	To the within 2. To the i	ž	29b. Signature and title of certifier				License				d. Date signed		
	/		Mary	_ ^	1.0		Do	05	517	-1	8/1	4/2	206.
	5		30. Name and address of person who con Sebastico K	mpleted cause of de	eath (Item 23a) (Type	Print)	. E.	ster	er V	ANGIORE	BAL	7. V	106.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1 ,							

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar		State of	Maryl		oartmer e <i>rtificat</i>			nd M	lental Hy	giene Reg. No.	. 900	20100
			1. Decedent's Name (Fir	st, Middle, L	ast)			-				2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Della Knotts									AUG	14	2006	06:10 AM
	Examin		4a. Facility Name (If not		4 .	PITA	12			Location of			4c. (	County of Death	n/a
	Funeral Director		5. Social Security Number 213-26-8584	er 6.	Sex 1□M 2 F	7. Age (In y	vrs. last birthda Yrs.	y) If Unde Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da 01/11		9. Birth Cou	place (State or Foreign ntry) MD
-	p	-	Usual Residence of Dec			100	City, Town or	Location			-				10d. Inside City Limits
	anyla show	7		. County					l and	(City)					1√2 Yes 2 □ No
	the M	Director	MD 10e. Street and Number	n/a			Baltimor	10f. Zi		(CILY)			10n Citiz	en of What Cou	
	with	ᄒ						101.2.		0.	1229			USA	,
	ne 23	era	3336 West Cato	n Avenu	12. Was Dece	dent Ever i	n U.S. 1	3. Was Dece	dent of H			ecify Yes or No Rican, etc.)	)- 1	4. Race - Ameri	
21215-0036	should be filed within 72 hours after death with the Maryland of Manial Hygiene. I marked other than "natural", or items 23s or 28s-f show umstic event, the Madical Examiner must be notified at	by Funeral	1 Never Married 3 Widowed 4		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	rces?		If Yes, spe 1 ☐ Yes		n, Mexican, Specify:	Puerto	Rican, etc.)		Black, White, Specify: Blac	
0-0	72 ho	Completed		Decedent's l	Education rade completed)		16a. De	cedent's Usu	al Occupa	ation	of worki	na	16b. Kin	d of Business/Ir	
216	ithin 7	npie	Elementary/Secondar		,College (1	-4or 5+)		ve kind of wo		d)g	<b>0. 110</b> 711.	,,,g	-1-	1 1.h.	
2	filed wi Hygien Ither th ent, the	Con	7th		n/a		t	echnici	an	40 Mark		(F) - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	L	ntal labo	oratory
Pu	be filed tal Hyg ed other event,	Be	17. Father's Name (First	, Middle, Las	:t)							(First, Middle	, maiden :	sumame)	
Maryland	is 1 and 2 should be of the state of the state of the state of the state of other treumstic ever	ᅀ	Tom Turner  19a. Informant's Name/	Dalationship	(Tuna Print)		10h M	ilina Addras	(Street			urner	er City or	Town, State, Zi	n Codel
Na Na	and 2 sho ealth and I n 27 is my		Harvey Knotts					-				timore,	-		p code)
	1 and 2 Health tem 27		20a. Method of Dispositi		iki -	20	b. Place of Dis					Date		ation - City or T	own, State
Baltimore,			1 ⊠Burial 2 □ Cr 4 □ Donation 5 □			State	cemetery, d estern C		other plac	1	ng /1 α	/2006	Po1+	imore, M	,
量	교문문문		21. Signature of Funera			I W	estem C		nd Addres			ie Funer			
ä	Depermine Important		Lune	la	Jones	$\supset$	1					ltimore,		21217	
1			23a. Part1. Enter the di shock, or heart fail	sease, or con	nplications that o	aused the d	leath. Do not	enter the mo	de of dyin	ng, such as o	ardiac (	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Fina disease or condition				NITO	A	COU	RED	,	PNEU	MOI	VIA	Onset and Death
	/Medical		resulting in death)		u		sequence of):		477	a serve					
	Examiner		Sequentially list condition	ons,	b		SEPT	10	51	tock					10 days
	<u>s</u> 4/6	Examiner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurior)	g 4	Due to		sequence of):	- 01	=^/	AL	G	FILUE			10 days
	be executed ician end burial-transit	хап	that initiated events resulting in death) Last		c	or as a con	CUTE sequence of):	, K	=/ \ /	72	//	FILUE	<u></u>		10 -(1/3
4 09	be ex	ical E			VEN	ITIL	47/01	1 AS	500	IATE	7	PNEC	MNI	VIA	5 days
7 - 7 - 289	ificate g physics the				0		( ( ( ) )		200			7,7,1	7-10-7		
) E L	The law requires that the death certificate be executed to has been signed by the ettending physician end age 2 should be detached for use as the burial-transi	Physician/Med	IF FEMALE:  23b. Was decedent pre in the past 12 mon 1 Yes 27 No 9 Unknown	ths?		irth 2 🗍 F ant at time	etal death	3 □Ectopic p 5 □ Other (s					2	3d. Date of deliv Month	rery Day Year
۵	s that the med by a detac	by Pr	Part II. Other significan	t conditions	contributing to d	ath but not	resulting in the	underlying	cause giv	en in Part I.		23e. Did (	obacco us	e contribute to	the cause of death?
rds	w requires been sign should be											10	Yes 2□	No 3 Pro	bably 4 □Unknown
Sol	aw re us bec 2 sho	Completed										24a. Was		24b. Were aut	opsy findings available ompletion of cause of
~ ~		No.										perfo	rmed?	death? 1 ☐ Yes	2 No
77 Vital	ician: Tector, prector, p	Be (	25. Was case referred t examiner?	o medical								Check only	_		
\2 \ \2 \ \2	Physic this ce	To	1 ☐ Yes 2 X No				2 🗆 ER/Outpa							□Other (Speci	fy)
	Jing P	on:	27. Manner of Death 1 Natural 5	☐ Pending		of Injury th, Day Yea	r) 28b. Time Inju		28c. Injur Wor			28d. Describe	how injury	occurred	
sio	eatl or:	icati	2 Accident 3 Suicide 6	investigati	be 200 Place	of Injury	At home, farm,	M date		Yes 2□N		29f Location /	Street and	Number or Pur	al Route Number.
× Division	F 0 F C	Certification:	4  Homicide	determine	buildi	ng, etc. (Sp	ecify)					City or To	wn, State)		
	To the Hospitel c within 24 hours at To the Funerel D completely filled in	Aedicai	(Check only 2 (	Medical Ex	Physician: To the aminer: On the b and man			investigatio	n, in my o	pinion, deat			date and	place, and due	to the cause(s)
	To With	Σ	29b. Signature and title	от селлиег	RND1	200		29		e number 1990	26			signed (Month)	
	1						(h. – :						7700	1 14	2000
	Vè		30. Name and address	or person wh NK	o completed caus		(Item 23a) (Tyl	oe, Print) 900	CA	TON	AI	E. 1	BALT	IMORE	2006 MD 21229
	Sta	te	31. Date filed (Month, D	ay, Year)	₽2. F	egistrar's S		,							

DHMH 17 Rev 1/2001

Registrar

AUG 1 6 2006

1- For Amend #5 Per FH G858 8/16/06 JE Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** AUGUST 13, 2006 KOTOVA 12:07 Pm GALINA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON If Under 1 Year | If Under 24 Hrs. 5. \$24a45a477441966 7. Age (In yrs. last birthday) 8. Date of Birth 08/22/1947 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕡 F 214037-1506 58 KIEV Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.

and if Health and Mental Hyglene "ratural", or iteme 23s or 28s-f sho wit: If tem 72 is marked other than "ratural", or iteme 23s or 28s-f sho and it or the traumatic event, it is Madical Examinism must be modified at any or other traumatic event, it is Madical Examinism must be modified at 1 ☐ Yes 2 🕱 No Director BALTIMORE BALTIMORE MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 SUNTOP COURT #201 21209 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: ģ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KOTOVA **EGOROVA** NIKOLY NINA ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 SUNTOP COURT #201 - BALTIMORE, MD 21209 SEMYON KOGAN / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment Important: If any Injury or once. DRUID RIDGE CEMETERY | 08/15/2006 PIKESVILLE, MD 4 □ Donytion 5 □ Other (Specify) Funeral Service Live 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part l. Enter the disease, or complications that Paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastatic me Canoma months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and or injury Due to (or as a consequence of): Examiner attending physicien and for use as the hurial or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death.

Director: Aft investigation 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funerel C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 125205 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Balto and 2,20% 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2006 Registrar

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		1 - State Registrar		Certificate of Death	Re	g. No. UUb	25/98
Physi	cian	Decedent's Name (First, Middle, Last)	1		Date of Death     Month	Day Year	3. Time of Death
/Med		Alice Marie	Livington			08 2006	1:07 AM
Exam	iner	4a. Facility Name (If not institution, give street Catangrille Commons	Nursias Ho	4b. City, Town, or Location o	i Death	4c. County of Death  Baltimos	ø
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) If Under 1 Year If Under 2		9. Birth	place (State or Foreign
Directo		218-48-3359 10M	218 8 6	Yrs. Months Days Hours	Min. (Month, Day, 05/20/		SC SC
and *		Usual Residence of Decedent  10a. State 10b. County	10c. City	. Town or Location			10d. Inside City Limits
Maryla febo	ō	MD Baltimore		timore			1 ☐ Yes 2 🗷 No
ith the Marylar or 28a-f ehow	rect	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Cou	ntry?
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r dea	Iner		Was Decedent Ever in U.S Armed Forces?	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ameri Black, White,	
s afte	by Fi	1 Never Married 2 Married 3 M Widowed 4 Divorced	1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Q	\
if ied within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene.  Other than "natural", or teeme 23e or 28e-f ehow ent, the Medical Executing Franche netiting at		15. Decedent's Educat	ion	16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	
A Los	pie	(Specify only highest grade c Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	of working		
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laryiano Kik Should be filed withir and Mental Hygiene. ie marked other than aumatic event, tra M	မ	Walter Johnson  19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing Address (Street and Number	r or Rural Route Number		Code)
IN and 2 allth a 27 is		0	aughter)	5350 Sinclair Lane			
of Health of Health litem 27		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Pl	ace of Disposition (Name of metery, crematory or other place)		20c. Location - City or T	
Pages ment of lant: If its ury or o		4 Donation 5 Other (Specify)	Kin State	a Memorial Park 8	/15/06 P	Sandallstow	MU
permit. Pages: Department of Pluportant: If ite		21. Signature of Funeral Service Licensee		22. Name and Address of Facility	Euneral Svc		
4026	7	Vaugher C, G.	ions that caused the death		Pike, Baltin		Approximate
		shock, or heart failure. List only one	cause on each line.	. Do not enter the mode of dying, such as t	cardiac or respiratory arre	551,	Interval Between Onset and Death
Physician /Medica		disease or condition resulting in death) a	Due to (or as a consequ	ence of):	· · · · · · · · · · · · · · · · · · ·		M
Examine	r	Sequentially list conditions h	Chran	4'c Remel of	ailing		Zy.
<u>ت</u> و	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):			
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th cer tendir	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 morphs?	If yes, outcome of pregnar 1 Live birth 2 Fetal			23d. Date of deliv	•
the at	Physician/Med	1 Yes 2 D 40	4☐Pregnant at time of de 9☐Unknown	ath 5 Other (specify)		Month	Day Year
that the ed by detac	Phy	Part II. Other significent conditions contri	outing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
OI VILGI NECOLUS, T.O. DOX OC Physician: The law requires that the death certifics this certificate has been signed by the attending ph ral director, page 2 should be detached for use as the	d by				1 □ Ye	s 2 No 3 Pro	pably 4 Unknown
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cian: cian: ector, p	Be (	25. Was case referred to medical examiner?			of Death (Check only one		
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Attending r death.	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of		w injury occurred	
Attan ar deat ector: by the	Certification:	a Could not be	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory, office	28f. Location (Str City or Town	reet and Number or Run	al Route Number,
rs after all Dir	Cert						
To the Hospital or Attanding Physician: The law within 24 hours atter death.  To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exeminer	On the basis of examinati	viedge, death occurred at the time, date and on and/or investigation, in my opinion, deat	d place, and due to the ca h occurred at the time, da	use(s) and manner as sate and place, and due t	stated. o the cause(s)
o the ithin 2 o the	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	29	9d. Date signed (Month,	Dey, Year)
⊢ 3 ⊢ 3		* Bleer &	~	\$ T D3694	2 A	refuse 11	, 2006
		20 News and address of person who com-	pleted cause of death (Item	23a) (Tuno Print)		<i>d</i>	/
3		30. Name and address of person who comp	A A A	ZSA) (Type, FIIII)	01 . 110	1	.000
-	tate	31. Date filed (Month, Day, Year)	My), 1009	Frederick Rd.	Ce tensos'll	le, mp ?	1228

DHMH 17 Rev 1/2001

06-06037 Please Type or Print in Black Indelible Ink Norman Lockhart State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 13, 2006 0045 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 5412 Old Court Road Room 127 Randallstown Baltimore County 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Director 05-02-1926 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country old 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married 1 V Yes 2 If Yes, Give Year Yes 2 No specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 60 Khart Sinclaur 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, 1 V Burial Donation Other Specify disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and /Medical Death Acute and chronic aspiration pneumonia Imm di te Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of). Physician/Medical X UNPENDED AMENDED item#23a,PII,27,perME,g860,10/2/06 TT Be Completed by

Division of Vital Records, P.O. Box 68760,

b. Was decedent pregnant in the past 12 months?	33c. If yes, outcome of preg Live birth Pregnant at time of de	2 Fetal deat		ancy	Month	elivery Day	Year
art II. Other significant conditions co	ntributing to death but not re	esulting in the underlying	ng cause given in Part I.	23e Did toba	cco use contribu	ite to the caus	se of death?
Remote cerebral infa	rcts, hypertens	ive heart dis	ease;	1 Yes	2 <b>V</b> No 3	Probably 4	Unknown
dysphasia				24a. Was an autopsy performe	prio		ndings available on of cause of
				1 <b>Y</b> Yes 2		Yes	2 No
i. Was case referred to medical examiner?			26.Place of Death (Check	only one)			
1 ✓ Yes 2 No	oital 1 Inpatient 2	ER/Outpatient 3	DOA Other Nursii	ng Home 5 Re	sidence 6	Other Scene	7.0
. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c Injury at Work?	28d. Describe how	v injury occurred		
X Natural 5 Pending Investigation	(Month, Day, Year)		1 Yes 2 No				
Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, street, facto	ry, office building, etc.	28f. Location (Stre or Town, Stat		or Rural Rout	le Number, City
Homicide	(Specify)		1	1		-	- 13
Ga Certifier 1 Certifying Physician:	To the best of my knowled	ge, death occurred at the	ne time, date and place, and	d due to the cause(s	s) and manner as	s started	

2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

August 15, 2006

DHMH 17 Rev 1/2001 OCME 2006

Registra

**Medical** 

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature Marito de

06-05805 Please Type or Print in Black Indelible Ink Muriel Lopez State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month 1528 hrs **Medical Examiner** August 5, 2006 MURIEL LOPEZ 4a Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Baltimore** Bon Secours Hospital N/A If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Foreign NEW YORK Months Days Hours Min Director M 2X F 54 10/11/1951 119-44-9923 Usual Residence of Deceden 10a. State 10b. County IOc City, Town or Location 10d Inside City Limits 1 Yes 2 XX No 28a-f show narked other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at once. HARFORD CO JOPPATOWNE MARYLAND Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 310 BURNSIDE COURT 21085 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces? White etc 1 Never Married 2 Married Yes 2 X No f Yes, Give Year within 72 hours after 3 X Widowed Divorced Yes 2 X No specify: Specify: AFRICAN AMERICAN t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner 2 16a Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A 12th grade 4vrs UNEMPLOYED Pages 1 and 2 should be filed within 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EUGENIA BRINKLEY AUGUSTUS LYLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ္ပ 19a Informant's Name/Relationship (Type, Print) 310 Burnside Ct., Joppatowne, Maryland 21085 Harry dePondicchello/Brother 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Burial 2 X Cremation 3 Removal from State Important: I 08-10-06 METRO CREMATORY BALTIMORE, MARYLAND Donation 5 Other Specify. 5 permit 1 22 Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, wown 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Right femur fracture with complications Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical X UNPENDED AMENDED the attending physician ed for use as the burial item#23a,PII,27,28a-f,perME,g859,9/1/06 TT Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? ģ End-stage renal disease Yes 2 ✓ No 3 Probably 4 Unknown Completed certificate has been 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25 Was case referred to medica 26.Place of Death (Check only one) director, Be Other<sub>4</sub> examiner? Hospital: 1 ✔ Inpatient 2 Nursing Home 5 this ER/Outpatient 3 DOA Residence 6 2 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) After Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No Pending 8/4/2006 Fnd 6:15 am subject fell 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 55 Wade Road Catonsville, 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. within 24 hours after death To the Funeral Director:

> s of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 31. Date filed (Month, Pay Year) 32. Registrar's Signature State 2006 ERECUIO Registrar

Homicide 29a. Certifier 1

29b. Signature and title

30. Name and addre

determined

(Specify)

nd manner stated

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2 Medical Examiner: of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 6, 2006

Spring Grove Hospital

Medical

one)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 State Registrar<mark>Amend #7 Per FH C858 8/16/06 JH</mark> Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav 245pm RANK 10 tuGUST 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

11 17 SECOURS HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F <del>89</del> 88 Yrs. Director 225-16-2961 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location rthan "natural", or Items 23s or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits **Funeral Director** 1 XYes 2 No MD NA Baltimore 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 2020 Penrose Ave 21223 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Black 3 Xividowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Car Wash 12th grade adment of Health and Mental Hyg ortant: If item 27 is marked other Injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be James H. Martin Mary Lee Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tree once. Hallie Woolfolk-Niece 11909 Homestead Place, Waldorf, Md 20601 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 8/17/06 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner CHRONIC PUL MOMARY OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year signed by the a 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? of Vital 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending P safter death. I Director: After t d in by the funera After t Certification; 28d. Describe how injury occurred Division 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel of within 24 hours all To the Funeral D 1 Centifying Physician: To the best of my knowledge, death continued at the time, data and place, and due to the cauca(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ourle 030272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILLEN BON SECOURS HOSPITAL THOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 6 2006 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	For State Registrar	State of Maryland	/ Department		Mental Hygie	211116	2580			
ician dical	1. Decedent's Name (First, Middle, Last)  Heleno Mo	ore			2. Date of Death Month	Day Yeer 1 2006	3. Time of Death 455 PM			
niner	5. Social Security Number 6. Sex	neet and number)  AT Y Ghd Medica  7. Age (In yrs. Ia:  M 2 ST 51	Center	Own, or Location of Death  Baltimor  Year If Under 24 Hrs.  Days Hours Min.	e	ear) Countr	ice (State or Foreig y) MD			
олсь. To Be Completed by Funeral Director	Usuel Residence of Decedent  10a. State  10b. County		Town or Location			100	d. Inside City Limi			
Directo	MD NA  10e. Street and Number  301 KEY AVENUL	_	MORE 10f. Zip	Code 21224	10g.	Citizen of What Countr				
by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Deced	ent of Hispanic Origin? (S fy Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK				
Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usua (Give kind of wor life. DO NOT us SECURI	( done during most of wor e retired)	king 16t	b. Kind of Business/Indu				
To Be C	17. Father's Name (First, Middle, Last) MILTON MOORE			18. Mother's Nar	ne (First, Middle, Mail	den Sumame)				
	19a. Informant's Name/Relationship (Type SILAS PRICE, JR	FRIEND)		Street and Number or Ru	Iral Route Number, Ci		Code)			
	20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		EMORIAL 08.	19.06 AN	Location - City or Tow				
	21. Signature of Funeral Service License		VAUGHN 5151 BA	Address of Facility C. GREENE TO. NATU PINCE	FUNIERAL &	SERVICE ID 21229				
dical Examiner	shock, or heer failure. List only on Immediate Cause (Final disease or condition resulting in death)  Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque  Due to (or as a conseque	nce of):	hage			nterval Between Onset and Death			
by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year							
	Part II. Other significent conditions conf	ributing to death but not result	ing in the underlying ca	use given in Part I.	23e. Did tobac	co use contribute to the	,			
Completed					24a. Was an autopsy performed	d? death?	pletion of cause o			
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Nnpatient 2 ☐ E	R/Outpatient 3 DO	Other	ath (Check only one)	e 6 □Other (Specify)				
Certification: T	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  2 Natural 5 Pending investigation 6 Could not be determined	1 1	М	lc. Injury at Work? 1 ⊟ Yes 2 ⊟ No	28d. Describe how i	injury occurred	Route Number,			
Medical Cer										
Me	29b. Signature and title of certifier	MO	290	License number	Date signed (Month, Day, Year) Aug 11 2006					
State	30. Name and address of person who could have a place May lucci at 1. Date filed (Month, Day, Year)	mpleted cause of death (Item 2 22 Soth Greene 32 Aegistrar's Signaty	Street Balt	imore MO 212	-ol					

DHMH 17 Rev 1/2001

Registrar

6 2006

06-05924 Charles Mcnemar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate of	Death	, 0	g. No. 200	5 2580
Phy <del>s</del> ici Medical Exam		Decedent's Name (First, Middle, Last)     Charles W. McNemar, I	ΙΙ		2. Date of Death Month August 9, 2		3. Time of Death 1140 hrs
		4a Facility Name (if not institution, give street and number)		b. City, Town, or Location of Dea		4c. County of Death	
Funeral		Howard County General Hospital  5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	Columbia  If Under 1 Year If Under 24h	drs 8. Date of Birt	Howard h(MM/DD/YYYY) 9. Birt	hplace (State or
Director		212-48-3127 X <sub>M 2</sub> F	59 <sub>Yrs.</sub>	Months Days Hours M		6 1047 Foreig	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	on			10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	or	MD Baltimore	Catons	ville			1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1209 Tugwell Drive		10f. Zip Code 21228	10	g. Citizen of What Coun United Stat	
with the 1s 23a o e notifi		11. Marital Status 12. Was Decedent	Ever in U.S. 13. Was	Decedent of Hispanic Origin? (	Specify Yes or No-		
r death w or items	Funeral		No If Ye	s, specify Cuban, Mexican, Puer		White, etc,	nite
hours afte 'natural'', Examiner	þ	Widowed 4 X Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade com		Yes 2 X No specify s Usual Occupation (Give kind of	f work done	Specify: VVI	
36 thin 72 ho te than "na edical Ex	etec	Elementary/Secondary (0-12) College (1-4 or 5	during mo	st of working life. DO NOT use r Oraftsman		Air Cor	
5-0036 led within 72 Hygiene other than the Medical	Completed	17. Father's Name (First, Middle, Last)		18.Mother's Nar	ne (First, Middle, M	aiden Surname)	
21215-0036 vuld be filed within 7 Mental Hygiene marked other than	Be	Charles W. McNemar, Jr.			beth Wood		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera. In the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f she important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the <u>Medical Examiner must be notified at once</u>	5	19a Informant's Name/Relationship (Type, Print) Erin McGinnis (Daughter)	19b. Mailing 2257 M	Address (Street and Number of lerion Pond W	r Rural Route Numi oodstock ,	ber City or Town, State, Maryland	Zip Code) 21163
ore, MD s. I and 2 sho of Health and If item 27 is		20a, Method of Disposition  1   X   Burial   2   Cremation   3   Removal from Sta	crematory or other	ion (Name of cemetery, er place)	Date	20c Location - City or	
Baltimore, permit Pages I an Department of Hea Important: If iter		4 Donation 5 Other Specify: 24 Sunature of Funeral Service Licensee	Meadowridge	Memorial Park 8/	15/06	Elkridge, D	-
Balt permit Depart Impor injury		Challet the country of the country o	A Gar	me and Address of Facility Y L. Kaufman F O Washington B	uneral Ho Ivd Elkr	ome at MMP, ridge, Mary	Inc. Land 21075
Physician /Medical		23a. Part I finter the disease, or complications that caused the failure List only one cause on each line Complication.	the death. Do not enter the ations of hype	mode of dying, such as cardiac rtensive atheroscle	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. disease asso  Due to (or as a conse-	ciated with lo	cal anesthesia for	an electiv	e repair of nal fistula	Death
pot.	_	Sequentially list conditions, if any, leading to immediate    b					
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated					
executed an and al - transit		events resulting in death) Last Due to (or as a consect d.	quence of).				
×e = -	/Medical			II,27,28a-f,penÆ,	3860, 10/20,	/06 TT	
76 icat		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcom		al death 3 Ectopic preg	nancy	23d. Date of delivery  Month D	ay <b>Ye</b> ar
Box 68's death certificate attending	ysician	1 Yes 2 No 9 Unknown g Unknown	ime of death 5 Oth	er (Specify)			
P.O. Es that the cigned by the general post detached	by Phy	Part II. Other significant conditions contributing to death	but not resulting in the ur	derlying cause given in Part I.	23e Did tob	pacco use contribute to the	ne cause of death?
- 83 En e		Diabetes Mellitus; Overweight			-	2 No 3 Proba	
Division of Vital Records, tal or Attending Physician: The law require and the above the state death the certificate has been sited in by the funeral director, page 2 should be	Completed				24a Was a autops perform	y prior to co	opsy findings available impletion of cause of
tal Rection: The Coertificate I	a)	25. Was case referred to medical		26.Place of Death (Chec	1 Yes 2 k only one)	No 1 ✓ Yes	2 No
f Vita Physici er this co	To B	examiner?  1 ✓ Yes 2 No Hospital: 1 ✓ Inpatier				Residence 6 Other:	
on of ending P ath or: After he funera	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Ye   28. Date of Injur (Month, Day Ye   27. Accided Investigation   28. Date of Injur (Month, Day Ye   28. Date of Injur (Month, Day Ye   28. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month, Day Ye   29. Date of Injur (Month)   29. Date of In	y 28b. Time of Inj ar) unknown	ury 28c. Injury at Work?	unknown	ow injury occurred	
ivisi or Att after de Directe	Certification:	3 Suicide 6 X Could not be 28e Place of Inju	ury - At home, farm, street	, factory, office building, etc		reet and Number or Rura ate)St. Agnes Su ity, MD	al Route Number, City
Division  Bospital or Attene 24 hours after death Funeral Director:		20a Certifier	gical center				
D To the Hospital within 24 hours To the Funeral	Medical	(Check only one)  2 Medical Examiner: On the basis of exam and manner stated					
F % F 8	Ä	29b. Signature and title of certifier		29c License number		29d. Date signed (Mont	h, Day, Year)
1/2:		30. Name and address of person who completed cause of de	eath (Item 23a)	O.C.M.E.		August 11, 2006	
104		Ling Li, MD Assistant Medical Examiner	111 Penn Street	, Baltimore, MD 21201			
Si Regis	ate trar	31 Date filed (Month, Day, Year) 32 Registrar' AUG 1 6 2006	s Signature	e e			
Contract -	_	The state of the s					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) 25804 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 14, 2006 5:08 P Rose Ruth Martin August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6732 Marvin Avenue **Eldersburg** Carrol1 If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2ŒF 81 Jan.16,1925 Director 219-16-9446 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or then "natural", or itema 23a or 28a-f sho 1 ☐ Yes 2 No Director Maryland Carrol1 Eldersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6732 Marvin Avenue 21784 death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atternent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other then Homemaker Own Home 17 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vincent Alimo Laura Catenzaro ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 William C. Martin, Sr. Husband 6732 Marvin Avenue: Eldersburg, Maryland 21784 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite eny Injury or ot once. 1 

Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 8/18/06 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fureral Service License <u> 1630 Edmondson Avenue; Catonsville</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 mon Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe 2 3 No certificate 1□ Yes or Attending Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Indence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A: Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ut 16, 2006 30 Name and address of person (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 6 Registrar

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Division of Vital Records, P.O. Box 68760,	be Hospital or Attending Physician: The law requires that the death certificate be executed
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		State of Maryland / Department of Health and M			0.57.0.05
	1	For State Certificate of Death		eg. No.2 0 0 6	25805
Dhysisia		1. Decedent's Name (First, Middle, Last)	2. Date of Deal Month	th Day Year	3. Time of Death
Physicia /Medica	al -	LOUISE S. MURPHY	08	10 2006	13:20 M
Examine	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  () u) ve (sity Specialty He by, tel Baltimore		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Funeral Director		215-24-3630 1 M 2 F 76 Yrs. Months Days Hours Min.	127087	77929 MA	RYLAND
D .		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County           10c. City, Town or Location		1	0d. Inside City Limits
/anyla	ō	MD HARFORD EDGEWOOD			1 ☐ Yes 2 ☐ No
28a-	rect	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	ntry?
ours after death with the Marylan raf', or Items 23a or 28a-f show Ever: it eff intest be notified at	Funeral Director	2102 BROWN COURT 21040		USA	
ems (	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spr. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2☒ No Specify: Year or Dates:		Specify: BL	ACK
filed within 72 hours after death with the Maryland Hygiene ther then "natural", or Items 23a or 28a-f show ant, the Medical Evar is at must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/In	dustry
thin 72 9. Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Give kind of work done during most of works life. DO NOT use retired)  If DO NOT use retired)	ing	DOMEGRA	
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should be ind Mental s markad c umatic ev	ပ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura	al Route Number	r, City or Town, State, Zip	Code)
and 2 sauth ar n 27 is		ARMALENE MURPHY / DAUGHTER   3228 AVONDALE AVE,	BALTIM	MORE, MD 2	1215
as 1 a of Hea of Hear rothe		20a. Metilod of Disposition 2 Depression 2 Depression State cemetery, crematory or other place)		20c. Location - City or To	own, State
Pagas ment of ant: if it ury or o		'4 □Donation 5 □Other (Specify) GARDEN OF FAITH 8/1	7/06	ROSEDALE,	MD
permit. Pagas 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if item 27 is markad other than "natural", any injury or other traumatic event, the Medical Evagore.		21. Signatur Theral Service Licensee 22. Name and Address of Facility HC 4600 LIBERTY HE	OWELL F	TUNERAL HO	ME21207 ORE, MD
407.00		23a 2411 Fer the isease, or complications that caused the death Do not enter the mode of dying, such as cardiac			Approximate
Physician		or headfailure. List only one cause on each line.  Immer is Cause (Final disers or condition)  Codoo Arrhyltm. 2 2 ° Co	dime	nath	Interval Between Onset and Death
/Medical		dise for condition resulting in death)  Due to (or as a consequence of):	1	)	
Examiner		Sequentially list conditions b. Dilated Cordiny copia	My 2	° fo?	
ed isit	inei	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Congestive heart faulum	به ۵ ز مـ	6 (6)	
be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last   C. Due to (or as a consequence of):	α		
	al	d			
The law requires that the death certificate the has been signed by the attending phyoage 2 should be detached for use as the	Physician/Medic	IF FEMALE:			MA
ath ce	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
that the de ed by the detached	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown		ļ	
s that the ned by e detact	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to t	
w requires been signi should be		Anoxic Encephalipathy	1 □ Y	es 2 No 3 Pro	bably 4 🗹 Unknown
taw re tas be	Completed	COPD	24a. Was a autop	sy prior to co	opsy findings available impletion of cause of
	Con	Recipiratory Januare and Vent depend	perfor 1 □ Yes	2☑No 1☐Yes	219 No
ysicien: Th	o Be	25. Was case referred to medical examiner?  1   Yes   22   No   Hospital: 1   Impatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Ho		ne) ence 6 ⊡Other (Speci	6.1
Physer this eral d	<b> </b>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?		ow injury occurred	
ath. r: After	atio	2 Accident investigation A NA 1 Yes 2 No	N	1 *	
or Atterderinecton by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number or Rur m. State)	al Route Number,
pital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the o	ause(s) and manner as	stated.
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director,	ledical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, o	date and place, and due l	o the cause(s)
To th within To th	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month,	
		Learohauna mo D005048	-0	08/10/00	
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SEBLU ZERA-YOHANNES, 601 South Charles Street, B	altimo	e, MD 2	1230
Sta	ite	SEBLU ZERA-YOHANNES, 601 South Charles Street, B  31. Date filed (Month, Day, Year), AUG 1 6 2006  32. Rigistrar's Signatury, AUG 1 6 2006			
Registi	ar	AUG I O COULD DESCRIPTION TO THE			

		4	<b>I</b> _ S	or tate egistrar	State of M	1arylan		artment of H		Mental Hy	giene Reg. No. 2	06	25806
	Physicia			bedent's Name (First, Middle,	Last)	K	)oct	<		2. Date of Do Month Augu	Day	Yeer 2005	3. Time of Death
	/Medic Examin	er		cility Name (If not institution,	town	·		4b. City, Town, or	Location of Deal	ille	4c. Count	y of Death	ore
	Funeral Director		214	-12-1525	. C	kge (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min		1919	Coun	lace (State or Foreign try) y Land
	aryland show		10a. S				y, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes 2X No
	vith the M	Directo	10e. S	ryland  Baltimo Greet and Number 19 Maiden Choi			onsv <b>i</b> l	10f. Zip Code 21228			10g. Citizen of	What Coun	itry?
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. M	arital Status  Never Married 2 Marrie  SWidowed 4 Divorced	12. Was Deceder Armed Force	nt Ever in U. \$? <b>}</b> No		Was Decedent of H If Yes, specify Cuba  1 Yes 2 No	ispanic Origin? (Specify:	Specify Yes or N rto Rican, etc.)	o- 14. Ra	ce - Americ ack, White, ify: Wh:	etc.
Maryland 21215-0036	within 72 hour ene. then "netural" the Medical Ex	Completed b		15. Decedent's (Specify only highest mentary/Secondary (0-12)	Education		(Give	dent's Usual Decup kind of work done DO NOT use retired	durina most of wo	orking	16b. Kind of E		dustry
and 21	I be filed within ntal Hygiene. ed other than: event, ins Wa	Be		12 ather's Name <i>(First, Middle, L</i> Rufus	ast) Wiscott		HOII	emaker	18. Mother's Na	me (First, Middle	e, Maiden Suma		
laryla	2 should be f and Mental I is marked of	2	19a.	Informant's Name/Relationsh	p (Type, Print)		10	ng Address (Street					Code)
Baltimore, N	Pages 1 and in the part of Health nt: If Item 27 y or other tr		20a.	Isan Garde (Da Method of Disposition □ Burial 2 □ Cremation  □ □ Donation 5 □ Other (Sp	3 □Removal from Sta	0	Place of Disponentery, cre	Canter I  osition (Name of matory or other place ark Cemet	ee)	Date	le MD 20c. Location Baltimo	- City or To	
Baltii	permit. Pages. Department of the important: if ite any injury or of once.			Signature of Funeral Service	Hellocal		2	2. Name and Addre					
	Physician /Medical Examiner	Examiner	Sequence Caus	Part I. Enter the disease, or of shock, or heart failure. List of editate Cause (Final ase or condition (ting in death)  uentially list conditions, it is a condition to the conditions of the c	a	i line.	MON quence of):	•	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed at the best been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	resu IF FI	ting in death) Last  EMALE: Was decedent pregnant			ancy	□Ectopic pregnance				Date of delive	
P.O. B	at the death by the atte	hysicia		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnan 9☐Unknow	t at time of o		Other (specify)			N	Month	Day Year
	w requires that been signed to should be det	þ	Part	II. Other significant conditio	ns contributing to deat	h but not res	sulting in the t	inderlying cause giv	en in Part I.		I tobacco use co ] Yes 2 ☐ No	ntribute to t	he cause of death? pably 4 24 hknown
il Records,	: The law re- cate hes bee . page 2 sho	Completed								per	is an 24b opsy formed?	prior to co death? 1 Yes	opsy findings available impletion of cause of
f Vital	Physician: The this certificate ral director, pag	To Be	. 6	Was case referred to medical examiner?  □ Yes 2 □ No	Hospital: 1 ☐ Inp	atient 2	] ER/Outpatie	nt 3□ DOA Oth		eath <i>(Check onl</i> ) Home 5 Re	<i>rone)</i> sidence 6 □0	ther (Special	(y)
Division of	Jing After fune	Certification: 7	1	Manner of Death    Matural 5   Pending   Accident investig   Suicide 6   Could n	ation	Day Year)	28b. Time Injury	M 1	yat k? Yes 2 ∐No		e how injury occi		al Route Number,
Divi		Certifi		4 Homicide determi	ned 286. Flace of building	etc. (Speci	ify)	treet, factory, office		City or T	own, State)		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a	Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the be examiner: On the basi and manner	s of examin stated.	ation and/or i	nvestigation, in my	pinion, death oc	curred at the time	e, date and place	e, and due t	o the cause(s)
	To t To t	Σ	29b.	Signature and title of certifier	1 A2 0	M	1	29c. Licens	P C C G		29d. Date sign	ied (Month,	Day, Year)
	5		30.	me and ad ress of perso	no completed cause	of death (Ite	m 23a) (Type	, Prin	1001	i	D 1	7 ,	2,2000
	St Regist	ate rar	31.	Date filed (Month, Day, Year) AUG 1 6 20	32. Red	istrar's Sign	ature for	Les M	on oice	Lan	e Dal	F1437	2,2006 2,2006 e,M) 21=3

		1	•	State of Maryland	/ Depa		t of He	ealth a		ental Hygi	ene g. No.	2006	25807
	E. 30	_	Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Thelma Louise	Potts						August	14	2006	6:30A M
200	Examin		4a. Facility Name (If not institution, give str			4b. City,	Town, or	Location of	f Death		4c. C	ounty of Deat	h
		1	Corsica Hills Nurs	sing Home				evil]			1.	Queen	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la:		If Under Months	1 Year Days	If Under 2 Hours	Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year)	Co	hplace (State or Foreign untry)
	Director		217-12-2034	N ZLAF	Yrs.					Dec 31,	192	2 Pe	nnsylvania
	pc ≱	}	Usual Residence of Decedent  10a, State 10b, County	10c. City,	Town or Lo	cation					-		10d. Inside City Limits
	eho	5	MD Queen Ar		heste								1 ☐ Yes 2 No
	the N	Director	10e. Street and Number			10f. Zip	Code			16	a. Citize	n of What Co	untry?
	a or	급	1502 St Mary's Roa	ď			216	19			Uni	ted St	ates
	filed within 72 hours after death with the Maryland Hygione. Ither then "naturelt, or Items 23a or 28a-f ehow ant, the Medical Examination notified at	Funerai		. Was Decedent Ever in U.S	. 13.	Was Dece			gin? (Spe	cify Yes or No- Rican, etc.)		. Race - Ame	ncan Indian,
	ter d	ᆵ	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 X No					, Puerto F	Rican, etc.)		Black, White	
5	urs a	þ	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2K No	Specify:			S	pecity: Wh	ite
Ş	2 ho	Completed	15. Decedent's Educa	ation completed	16a. Dece	dent's Usu	al Occupa	tion uring most	of working	20	16b. Kind	of Business/	Industry
Š	hin 7	pie	(Specify only highest grade   Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired,						
7	be filed within 72 ho tal Hygiene. d other then "natur event, the Medical	Son	10			Homer	naker					wn Hom	e
2	m - 0 5	Be (	17. Father's Name (First, Middle, Last)							(First, Middle, A	Maiden S	umame)	
<u>a</u>		ဂ္	James Ozark Sipes							Mock			
Maryland 21215-0036	s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type			-				l Route Number,			
	and salth n 27		Rosemay Christenser		1502					ester,			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other ance.		20a. Method of Disposition  XXBurial 2 Cremation 3 Re		ace of Dispo metery, crei							ation - City or	
Ĕ	Pages ment of ant: If it ury or o		4 ☐ Donation 5 ☐ Other (Specify)	Mead				-		3/16/06	Elk	ridge,	MD
<u>a</u>	permit. I Departm Importal any injui		21. Signature of Funeral Service Licenses		Ga Ca	2. Name a	nd Addres . Kau	s of Facility fman	y Fune	ral Hom	e at	MMP	Tnc
<u>n</u>	70F = 9		INVOVE		72	250 Wa	ishin	gton	Blvd	ral Hom L. Elkr	idge	, MD'2	
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death. cause on each line.	Do not en	ter the mo	de of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
- N	Physician		Immediate Cause (Final disease or condition	END STAGE C	HRON	IIC	085	TRUM	PIVE	PULMON	ARY	DISGA	
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):						•		
1	Examilies		Sequentially list conditions, b.	Due to (or as a consequence									
-57	p ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00 0 00 10 10 10 10 10 10 10 10 10 10		.An-	~ A	u T		1-6			
	and tran	cam	that initiated events c.	Due to (or as a consequence		WE	1217	1 8	215	EASE			
60,	icate be executed physicien and s the burial-transit			Duo to (or as a corrector	01100 (01).								
687	cate t	dicai	d.										
9 ×	leath certificate attending phy I for use as the	/Me	IF FEMALE:	c. If yes, outcome of pregnan	ncv						22	d. Date of de	liven
Box	attendation	ian	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	□Ectopic p □ Other (s					20	Month	Day Year
o.	the s	ysic	1 □ Yes 2 ■No 9 □ Unknown	9□ Unknown	a 5(	_ Ott 161 (3	pochy/						
о. О.	The law requires thet the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the u	underlying	cause give	en in Part I.		23e. Did tol	acco us	e contribute to	the cause of death?
ds,	signed be del	b b	HYDO ALBU	MINEMEN						1 <b>1</b>	s 2 🗆	No 3□P	robably 4 Unknown
Ö	w requir been si should	ete		•		01	122			24a. Was a	n I	24b Were a	utopsy findings available
ž	has has	Completed		<b>FNTESTER</b>						autops	v	prior to death?	completion of cause of
a	icate			eral vasc	WAR	- 10:	13 EA			1 ☐ Yes		1 🗆 Yes	2 No
Vital Records,	Physician: r this certificant	Be	25. Was case referred to medical examiner?	ospital:	-D/O		Oth	ne.		(Check only on		□04b++ /C++	
	Phys ral di	. To	1 ☐ Yes 2 € No  27. Manner of Death	1 ☐ Inpatient 2 ☐ E 28a. Date of Injury	28b. Time o		28c. Injun Worl	4-9 140		me 5 Reside			icity)
Division of	Attending or death. ector: After by the fune	Certification:	1 ■ Natural 5 □ Pending	(Month, Day Year)	Injury	М		k? Yes 2 🔲	No				
isi	deat deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho		treet, facto	ry, office		1			Number or R	ural Route Number,
≥	after Dire	erti	4  Homicide	building, etc. (Specify	)					City or Town	n, State)		
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physi	ician: To the best of my know	viedge, dea	th occurre	d at the tin	ne, date an	nd place,	and due to the c	ause(s) a	ind manner a	s stated.
	• Ho • Fui e Fui	Medical	(Check only 2 Medical Examin one)	er: On the basis of examinati and manner stated.	ion and/or ir	nvestigatio	n, in my o	pinion, dea	th occurr	ed at the time, d	ate and p	place, and du	e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		~	25	c. Licens	e number	,		9d. Date	signed (Mon	n, Day, Year)
	. 2. 0		12:4	ha Due to	M.	1	1	350	45	3	8	1141	2006
~	m		30. Name and address of person who co	npleted cause of death frem	23а) (Туре	, Print)			1-6				
	")		1	Centreville R			ville	e, MD	216	17			
43	St	ate rar	31. Date filed (Month Pay, Teas 209	32 egistrar's Signat	we	PW							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Ment				
Certificate of Death	Reg. No.	2006	2500	] {
1.0 1 - 10	2 Date of Dooth	2 Tim	o of Dooth	_

	1- For State Registrar		Certifica	ate of D	eath			reg. Ivo.	JUD 6	100
Physician/ /ledical Examiner	Decedent's Name (First, Middle KATHER	RINE POLIT					2. Date of De Month August 1	4, 2006 Year	0835 P	
1	4a. Facility Name (if not institutio 231 Register Avenue				City, Town, or Lo			4c. County o	e County	
Funeral Director	5. Social Security Number 216-66-7196	6. Sex 7. Ag	ge (In yrs. last birti	**	f Under 1 Year Months Days	If Under 24H Hours M	8. Date of B	· ·	9 Birthplace (State Foreign Country)	
Maryland 28a-f show any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County  Maryland Balti	more	10c. City, Town Balti							City Limits
th the Maryland 23a or 28a-f sho notified at once.		/enue		1	Of Zip Code 2121	12		10g Citizen of Wh	at Country?	
s after death wirral", or items aniner must be	Widowed 4 Div	orced If Yes, Give Year or Dates:	XX No	If Yes,  1 Ye  Decedent's	ecedent of Hispa specify Cuban, N es 2 XX No Usual Occupation of working life. D	Mexican, Puer specify:	of work done	o- 14. Race White Specify: 16b. Kind of Bus	White	3lack,
5-0036 ed within 72 hour hygiene. other than "natu the Medical Exan	Elementary/Secondary (0-12)	College (1-4 or	5+)		abled	O NOT use I	etired)	N/A		
ore, MD 21215-0036 ss 1 and 2 should be filed within 77 of Health and Mental Hygiene. If item 27 is marked other than ther traumatic event, the Medical To Be Comple	Nicholas Polite	es				Cons	stance A			
MD 21 the 2 should alth and Me m 27 is ma aumatic ev	Angeline Polite		er 23	1 Reg	ester Av	enue E	Baltimor	<u> </u>	and 21212	
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	20a. Method of Disposition  1 XXBurial 2 Cremation  4 Donation 5 Other Sp.	n 3 Removal from St	20b. Place of cremati Dulaney	Valley	n (Name of ceme place) <b>Mem Gar</b>	8/	Date /19/06	Timoniu	City or Town, State  JM, Maryl	and
Baltimo permit. Pages Department of Important: i	21/Signature of Funeral Service	len Kerake			6500	York	Road B	altimor	neral Home e, Mary	land
Physician /Medical Examiner	23a Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	not Wound	ot enter the i	mode of dying, su	uch as cardiad	c or respiratory a	rrest, shock, or hea	Between	nate Interval Onset and leath
ted Instit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last	b. Due to (or as a cons								
		d								
x 68760, ath certificate be attending physici or use as the buri	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Uni	23c. If yes, outco		Petal Other	death 3 (Specify)	Ectopic preg	gnancy	23d Date of Month	delivery Day	Year
ires that the designed by the a signed by the a lbe detached for the detached for the by Physical by P		ions contributing to dea	th but not resulting	g in the und	erlying cause giv	en in Part I.			Probably 4	1
Division of Vital Records, P.C tal or Attending Physician: The law requires tha ris after death.  at Director: After this certificate has been signed led in by the funeral director, page 2 should be determined in the tall of the death.  To Be Completed by artification: To Be Completed by							24a Wa auto peri 1 🗸 Yes	opsy promed? d	Vere autopsy findingrior to completion of eath?  Yes 2	
tal Fician: certific		Magnital				ther Nur				
n of Vital   Jing Physician: Ther this certif futeral director, On: To Be (	1 Yes 2 No	28a Date of Inj		utpatient 3 Time of Inju			sing Home 5	Residence 6 verified how injury occurre		
Division os spital or Attending nours after death, neral Director: After filled in by the fune Certification:	1 Natural 5 Pend 2 Accident Inve	ding FOUND: Day, at 14, 200	FOL 6 0832	JND: 2 hrs	1 Ye	es 2 🗸 No	Subject sh	ot self		
Divis pital or A ours after teral Dire filled in b	3 Suicide 6 Couldete	ld not be	njury - At home, fa ngle Family H		ractory, oπice bui	liaing etc.	or Town,		on, MD	amber, City
To the Hos within 24 h To the Fur completely		hysician: To the best of r iminer:On the basis of exa and manner stated	amination and/or i		n, in my opinion, o	death occurre		e and place, and d	ue to the cause(s)	
A L	29b Signature and title of certific	pleud			29c License O.C.M			August 15,	ed (Month, Day, Yea	ar)
H	3 Name and a ress of person Laron Locke MD. A	who completed assistant Medical Ex	,	1 Penn S	treet, Baltim	ore, MD 2	1201			
	State 31. Date filed (Month, Day, Year) 32 registrar's Signature Registrar AUG 1 6 2006 Segistrar's Signature									

06-05957 Lorraine M. Rogers

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

TOTALITO WE TROS		1- For State Registrar	Otato	or iviarylation		tificate of		10 1010		eg No	the state of the s
Physic	an/	1. Decedent's Name (First, Lorraine M. ]							2. Date of Dea Month	Day Year	3: Time of Death
WEUICAI EXAIII	II iei	4a Facility Name (if not ins	_			4	b. City, Town, o	or Location o	August 11	4c. County of Dea	
		420 Hillview Drive					Linthicum			Anne Arunde	
Funeral Director		5. Social Security Number 214-50-7510		x 7. Agr M 2XF	e (In yrs. Ia	ast birthday) 62 Yrs.	If Under 1 Ye		Min.	th (MM/DD/YYYY) 9. B Fore 09, 1943	
áu e		Usual Residence of Decederation 10a. State 10b. Co.			10c. City,	Town or Location	on				10d Inside City Limits
and show acc.	ار ا	MD Anne	Arur	del	Lintl	hicum					1 Yes 2 X No
Maryla r 28a-f	rector	10e. Street and Number		7 . 7.0			10f. Zip Code		1	0g. Citizen of What Co	
ith the 23a or notifie	al Dire	420 Hillview  11. Marital Status	Drive	2, Apt. IC		S 13 W/as	21090		gin? ( Specify Yes or No	US.	A rican Indian, Black,
leath w r items	Funeral	1 Never Married 2	Married	Armed Forces?					Puerto Rican, etc.)	White, etc.	
after d	by F	3 X Widowed 4		If Yes, Give Year or Dates:			Yes 2 X N			Specify.	ite
2 hours "natur	ted I	15. Decedent's Education  Elementary/Secondary (		ly highest grade con College (1-4 or			's Usual Occup est of working lit		kind of work done use retired)	16b. Kind of Business Maryland Mod	
036 ithin 72 ne r than Tedical	Completed	12	,	0 = 11 = 9 = ( 1 = 1 = 1	,	Adminis	stratio	n		Administrat	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at once.	S	17. Father's Name (First, M	ddle, Last)						's Name (First, Middle,	Maiden Surname)	
2121 ald be i Mental marke	o Be	Donald Garey  19a. Informant's Name/Rel	tionship (T	ype, Print )		19b. Mailing	Address (Str		aine Garey nber or Rural Route Nur	mber, City or Town, Star	te, Zip Code)
MD d 2 shot lth and n 27 is		Kimberly Hage	en /	Friend		29 Gov	erners	Gate	Lane, Lint	hicum, MD	21090
ore,   s   and of Heal If item		20a Method of Disposition 1 X Burial 2 Crei	nation 3	Removal from Sta	ate (	Place of Disposi crematory or oth	er place)		Date	20c. Location - City of	
Baltimore, permit. Pages 1 a pepartment of He Important: If ite injury or other tring injury or other tr		4 Donation 5 Oti	er Specify		Meac	dowridge M			08/14/2006	Elkridge	, MD
Balt permit Depart Impor		2) sign jure of Functial S	rvice Licen	see N	01378	8 <b>Gar</b>	ame and Addre	iss of Facility	reral <u>H</u> ome at	Meadowridge M	/emorial Park
Physician		Z3a. Part I. Enter the disea failure. List only one	or comp	lications that caused	the death.	. Do not enter th	<i>) Wବସ</i> ୀୟନ e mode of dyin	g, such as c	ardiac or respiratory ari	est, shock, or heart	Approximate Interval Between Onset and
/Medica Examine		Immediate Cause (Final di	ease a.	Hypertensi			tic card	iovascu	lar disease		Death
		or condition resulting in de	b.	Due to (or as a cons	equence o	of).					
	iner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying C	ause	Due to (or as a cons	equence o	of).					
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executed an and al - transi	교 교			1							
- 0 '5 E	Medical	X UNPENDED IF FEMALE:	X	AMENDED ite		Ba,27,perl	E,g858,8	/23/06	TT	23d. Date of delive	
68760, certificate buding physicase as the bu	an/IV	23b. Was decedent pregna past 12 months?	t in the	1 Live birth		2 Fet	al death 3	Ectopic	c pregnancy	Month Month	Day <b>Y</b> ear
Box (e death ce the attence dor use	sician	1 Yes 2 No 9	Unknown	4 Pregnant at 9 Unknown	time of de	eath 5 Oth	ner (Specify)				
Vital Records, P.O. Box 68' system: The law requires that the death certificate has been signed by the attending director, page 2 should be detached for use as!	/ Phy	Part II. Other significant of	onditions	contributing to deat	h but not r	resulting in the u	nderlying cause	e given in Pa	art I 23e. Did t	obacco use contribute t	o the cause of death?
S, P. nires th signed d be de	ed by								_	s 2 V No 3 Pr	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director. After this certificate has been seled in by the fineral director, page 2 should it.	Completed								24a. Was		autopsy findings available completion of cause of
Rec The L ficate P	S								1 🗸 Yes		
Vital Vital hysician: this certi	Be Be	25 Was case referred to n examiner?	F	fospital: 1 Inpatie	ent 2	ER/Outpatient		Other <sub>4</sub>	(Check only one)  Nursing Home 5	Residence 6 🗸 Oth	er: Scene
n of V ing Phy After th	-	1 ✓ Yes 2 N 27. Manner of Death	)	28a. Date of Inju	ıry	28b. Time of Ir		jury at Work	? 28d Describe	how injury occurred	
Sion Attendig death. ctor: A	atio	1 X Natural 5	Pending Investigati	on				Yes 2			
Division of Vipial or Attending Phous after death.	Certification:	3 Suicide 6	Could not determine	be	njury - At h	ome, farm, stree	et, factory, office	e building, et	tc 28f. Location ( or Town,		Rural Route Number, City
ig 8 g i		4 Homicide  29a Certifier 1 Certify		(	v knowled	dge, death occur	red at the time.	date and pla	ace, and due to the cau	se(s) and manner as sta	arted.
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certif	Medical	(Circux only	-		-	-				and place, and due to	
F # F 5	×	29b. Signature and litle of	ertifier	$\sqrt{\Lambda}$	1			nse number		29d. Date signed (M	
		WIL	IX	1	1	- 00 - 1	0.0	C.M.E.		August 12, 200	
		30. Name and address of Susan Hogan M		completeଧ cause of ଜ stant Medical E			n Street, Ba	altimore, I	MD 21201		
	State		Year)	32. Ratistra		ure					
Regi	strar	AUG	1621	106 /	4.00	H. Cox	ade p				

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amend 1 tem 5 per fh 9862 12-14-06 vt
State of Maryland / Department of Health and Mental Hygiene? 2581 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** August 9, 2006 8:56 AMM David Roch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 464 S. Bentalou Street Baltimore n/a If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1/10/26 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5217-22-8442 unknown 6. Sex **Funeral** 176 M 2 □ F Yrs. Pennsylvania 80 Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State 10b. County \*how rai', or Itema 23a or 28a-f shov Examiner must be notified at 1 ⊠Yes 2 No Baltimore n/a Md Direct the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 464 S. Bentalou Street USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1. May 2 □ No 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: White þ 3 ₩ Widowed 4 □ Divorced "natural", ar than "natura the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked out any injury or other traumatic even pores. John Roch Verna Vass 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2810 Sandover Ct. Bonita, California 91902 Veronica Ann Perry / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 ☑ Other (Specify) tombment 8/18/06 Baltimore, Maryland 21. Signature of Funeral Service Louidond Parko Fulleral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Ce Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. arteriore Immediate Cause (Final malle Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and p The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician Completed by Physiclan/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day detached for 5 Other (specify) ☐Yes 2☐No of Vital Records, P.O. ey 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? peubis pe 2 No 3 Probably 4 □Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 1 No or Attending Physician: 26. Place of Death Check on one in by the funeral director. 25. Was case referred to medical exampler?
1 W Yes 2 No Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending 1 S atural 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To tha Funeral E filled To the Hospital [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8/11/06

State Registrar

31. Date filed (Month, Day, Year) AUG 1 6 2006



E Burillas us

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

022114

PAMBAN . DACHESS

mo, 2429

		1 - For State Registrar		arytaria / i	Department of I Certificate of	Death		Reg. No.	JUb	2581
Physici	an	Decedent's Name (First, Middle,	Last)				2. Date of D Month	Day	Year	3. Time of Death
/Medic		Jennifer	Wolfe	E	Rasmussen		August		006	3:15p <sup>™</sup>
Examin	er	4a. Facility Name (If not institution,				or Location of De	ath		nty of Death	
		Stella Maris H				Valley			imore	
Funeral Director		216-08-4492	1 □ M 2 □ STE	e (In yrs. last bii	rthday) If Under 1 Year Yrs. Months Days	If Under 24 H Hours Mi	n. (Month, D	ay, Year) 3, 1969	9. Birth Cou Mary	place (State or Foreign http) yland
death with the Maryland me 23a or 28a-f ehow Frant be notified at	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
Ba-f-	Director	Maryland Baltim	ore	Catons	rille					1 Tes 2 No
or 28	Sire	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	ntry?
23a	je	710 Meadowbrook	Ave.		21228			USA		
or ite	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? d 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent of In If Yes, specify Cub		(Specify Yes or Nerto Rican, etc.)	0- 14. R B Spec	ace - Ameri lack, White, cify: Wh	
"natural",	Completed	15. Decedent's (Specify only highest	Education	16a	Decedent's Usual Occup	pation	nding	16b. Kind of	Business/In	ndustry
hh 7	ple	Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of work done life. DO NOT use retire	d)	vorking			
e filed within al Hygiene. I other then " vent, the bis	Й	12	4		Manager			Moorel	and Co	orp.
oth of	Be (	17. Father's Name (First, Middle, L	ast)			18. Mother's N	ame (First, Middle	, Maiden Sum	ame)	
lental rked c	To B	Louis P	au1	Wolfe		Nadene	Enc	o1a	Dι	ıncan
I Heelth and Mental Hygiene. Item 27 is marked other then "natural; other traumatic event, the Mudical Ext		19a. Informant's Name/Relationshi Nadene Wolfe (M		19t 90	o. Mailing Address (Street )9 Vanderwoo	and Number or	Rural Route Numb Catonsvi	per, City or Tow Lle, MD	m, State, Zip 21228	o Code) 3
of Hee		20a. Method of Disposition			f Disposition (Name of ry, crematory or other pla	ce)	Date	20c. Location	n - City or To	own, State
Department of Important: If it eny injury or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp.			. Park Cemet		15/06	Baltim	ore, N	Maryland
orta inju		21. Signature of Funeral Service L			22. Name and Addre	ss of Facility	Loudon Pa	ark Fun	eral I	Iome
Depa Impo eny ir	de d				3620 Wilk					
Medical xaming physician and xamine as the burial-transit	edicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	a consequence	of):					
attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у			Date of deliver	ery Day Year
signed by the d be detached	þ	Part II. Other significant condition	s contributing to death bu	ut not resulting i	n the underlying cause giv	ven in Part I.		tobacco use co Yes 2 □ No		he cause of death?
s been sign 2 should be	Completed					· · ·	24a. Was	an 24b	. Were auto	opsy findings available
ete hes page 2 :	E							ormed?	death?	impletion of cause of
certificete rector, pag	CO	25. Was case referred to medical				26 Place of D	1 ☐ Yes	2 <b>X</b> No	1 🗆 Yes	2 L NO
this certific	0 0	examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 ☐ Inpatier	at 2 🗆 CB/O	utpationt 3 DOA Off				· · · · · · · · · · · · · · · · · · ·	HOGDIGE
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tn. : After this o funeral dir	5	1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	njury Wo	rk? Yes 2 □ No	Esd. Describe	now anjuly occ	ui1 60	
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rai Dire led in b	Certification:	4 Homicide determin	building, etc	:.'(Specify)			City or To	wn, State)		ar restorvantos,
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1X Certifying (Check only 2 Medical E	Physician: To the best of kaminer: On the basis of and manner sta	examination ar	death secured at the tild/or investigation, in my c	me date and pla ppinion, death oc	es, and dus to the curred at the time,	date and place	and due to	itated, the cause(s)
To t	Σ	29b. Signature and title of codifier			29c. Licens	3725		29d. Date sign	ned (Month,	
1		30. Name and address of person w	ho completed cause of do	aath (Itom 22a)		2162		8/	11/04	-
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C	10	DR. TARIQ MAHM 31. Date filed (Month, Day, Year)		JLANEY V	VALLEY RD.	TIMUNI	UM, MD 2	1033		
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AUGUST 11, 2006

JENNIFER RASMUSSEN

			1 - For State Registrar	State	of Marylar		artment of I rtificate of		nd Men	_	iene 19. No. 20 (	16	25812
			1. Decedent's Name (First, Middle, La	st)						Date of Death		ear	3. Time of Death
	nysici: 'Medic		Marie Ann Regan								1, 2006		4:43 A. M
Ε	xamin	er	4a. Facility Name (If not institution, give	e street and no	umber)		4b. City, Town, o	or Location of	f Death		4c. County of		
			Gilchrist Center  5. Social Security Number 6.5	in a	7. Age (In yrs.	hat hirthday	Tows o		A Hrs o	Data of Bidh	Balti		
	neral ector		214-14-4701	_M 2₹X	1. Age (III yis.	92 Yrs.	Months Days	Hours	Min.	Date of Birth Month, Day, Ne 20,	1914 I	Coun	lace (State or Foreign try) Land
D			Usual Residence of Decedent			,,,			pα	ne 20,	1714 1	nucy	ranu
arylan	1	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					1	Od. Inside City Limits
e Me	allie	by Funeral Director	Maryland Baltim	ore	H	ydes							1 ☐ Yes XXNo
with ti	g a	급	10e. Street and Number				10f. Zip Code			18	g. Citizen of Wh Inited S	at Coun tate	itry?
eeth	DIME	erai	6037 Church Lane  11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13 1	21082	dispanic Origi	in? (Specify		America 14. Race -		an Indian
fferd	and di	표	1 ☐ Never Married 2 ☐ Married	Armed F	orces?	1	Was Decedent of H		Puerto Rica	n, etc.)	Black,	White,	etc.
Surre a	Exac		3XVidowed 4 □ Divorced	If Yes, G Year or I	ive Dates:		1□ Yes <b>XX</b> No	Specify:			Specify:	vhit	te
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within ne	a l	d I	Elementary/Secondary (0-12)	College	(1-4or 5+)		DO NOT use retire	d)			A 11		
filed v	E E		12th 17. Father's Name (First, Middle, Last	,		п	memaker	18 Mother	's Name (Fir	st Middle M	OWN HON	ne_	
VICILIA K. I.A.	2	To Be	Wenceslaus Shimai						Kalis.		maideri Sumame)		
shoul nd M	te d	F	19a. Informant's Name/Relationship (			19b. Mailir	ng Address (Street				City or Town, St	ate, Zip	Code)
end 2	į	ļ	Bartlett C. Regai	ı, Jr.	(Son)		Church L						
es de la constant de	or other treumatic event, the Medical Examinar must be notified at		20a. Method of Disposition  1.XX Surial 2 Semation 3 E	1D	20b.	Place of Disno	eition (Name of	1	Date	2	20c. Location - Ci	ty or To	wn, State
- G 6	uryo		4 □Donation 5 □Other (Special		Mei	kaney v morial	gatory or other pla alley Gardens	2	lugust 2006	14, C	ockeysv	ille	, Maryland
permit. Departr	eny Inj		21. Signature of Funeral Service Lies	see		50	Name and Addre	ss of Facility	al Ham	o Inc			
40.	• a		( CALLON CALLON)			97	05 Belai	r Road	1; Ba	ltimor	e. Marus	and	21236
			23a Part1. Enter the disease, or com shock, or heart failure. List only	one cause on	each line.								Approximate Interval Between Onset and Death
Phys			Immediate Cause (Final disease or condition resulting in death)	a Vic	int H	P	ractive	with	corry	oliente	m		Weeks
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₽\ <b>4</b>	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						Jana .	1.5	ye,		
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ath o	or us	lan/	23b. Was decedent pregnant in the past 12 mgnths?	1☐Live	utcome of pregn birth 2 ☐ Feta	aldeath 3□	Ectopic pregnanc	у			23d. Date of Month		ry Day Year
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that	deta		Part II. Other significant conditions	ontributing to	death but not res	sulting in the u	nderlying cause gr	en in Part I.		23e. Did tob	acco use contribu	ute to th	e cause of death?
uires puis	ed bi	d by											ably 4 □Unknown
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The la	age 2	mo							_	autopsy perform	priced? dea	r to cor th?	npletion of cause of
ביים ביים ביים ביים ביים ביים ביים ביים	director, page 2	Se C	25. Was case referred to medical					26. Place o		1 ☐ Yes 2 leck only one		Y 0 S	2□ No
Phyalc	direc	To B	examiner? 1 ☑ es 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3□ DOA Ott				nce 6 Tother	(Specify	Hospice
- 6 4	nera		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date (Moi	of Injury oth, Day Year)	28b. Time of Injury	f 28c. Inju		28d.	Describe ho	w injury occurred		
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or At	in by	Certification;	4 Homicide determined	build	ding, etc. (Speci	iome, farm, <i>s</i> tr <i>fy)</i>	eet, factory, office			uny or lown,	eet and Number , State)		
pital	Pelli		29a. Certifier 1 Certifying Pl		tome	outodes dost	h convered at the t						Ma 31083
To the Hospital or Attending Physicien: The law requires that the death certificats be executed within 15 four law requires that the death certificats here has been closed.	completely filled in	Medical	(Check only 2 Medical Exel	niner: On the l	basis of examina	ation and/or in	h occurred at the ti vestigation, in my o	pinion, death	n occurred at	the time da	te and place, and	d due to	ated. the cause(s)
To the	dwo	Me	29b. Signature and title of certifier	450			29c. Licens	e number		29	d. Date signed (i	Month, I	Day, Year)
'	0		M. Anthons	Mly	ans,		020	700	-	A	UGUST	11,	2006
	18		30. Name and address of person	completed cau	ise of death (Ite	m 23a) (Type,	Print)	<i>C</i> ;	0		, -		
			W. A. Rilay	6 Bino	670	1 N-	Chule	o Jt.	Bal	to. Mo	d 213	عرن	
R	Sta egistr		31. Date filed (Month, Day, Year)  ALIG 1 6 20	06 32	Hegistrar's Sign	ayure do	29c. Licens 02s						

			1 - For State Registrar			nd / Depa <i>Cei</i>		t of H	ealth ar		•		006	25813
	Physici /Medic		1. Decedent's Name (First, Middle, Dorothy Elizab	<sub>Last)</sub> eth Robi	nson						2. Date of De Month Auaus	Day	Yeer 200	3. Time of Death
•	Examir		4a. Facility Name (If not institution, Upper Chesapea			er	4b. City,		Location of 0	Death			unty of Deat	
	Funeral		5. Social Security Number 6	i. Sex 1 □ M 2 □ F	7. Age (In yrs.	. last birthday) Yrs.	If Under Months		If Under 24	Min.	8. Date of Bi (Month, Di Dec • 2.		9. Birti	hplace (State or Foreign
1	Director		212-12-5619 Usual Residence of Decedent	X	87						Dec. 2	5, 191	O Ma	aryland
	Marylar f ahow	lor	Md. Harf	ord	10c. C	ity, Town or Lo		ingd	οn					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28s	Direc	10e. Street and Number				10f. Zip	Code				-	of What Co	ountry?
	deeth v ms 23e	erai	2917 Brightwat  11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Deced	210 lent <i>o</i> l H		n? (Spe	cify Yes or No Rican, etc.)		.S.A.	
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1430	72 hou	eted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua kind of wo	al Occupa	ation during most o	f workin	)g	16b. Kind	of Business/	Industry
14	d withir	omo	Elementary/Secondary (0-12) 12 years	College (	1-4or 5+)	_	es pe					cc	smetic	cs
	War y latter & L.Z. 1 2.2 should be filed within h and Mental Hygiene. 7 is marked other than " rsumatic event, the Mai	Be	17. Father's Name (First, Middle, La Joseph Levy	ast)							(First, Middle ne Sch		mame)	
2	Ivial ylalla d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	<sup>L</sup>	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailir	ng Address	(Street a			Route Numb		own, State, 2	Zip Code)
	ore, IV		Sandy Umerley/ 20a. Method of Disposition	daughter	20b.	Place of Dispo	sition (Nar	ne of			ltimor		21211	
7	Pages nent of I ant: If it		1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State Ba	cemetery, crer yview (				/17,	/2006		imore,	
8-13-	Dallillo permit. Pages Department of Important: If i any injury or once.		21. Signature of Euneral Service Li	censee							Home o			
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36	The COLUS, P.O. DOX 00/07. The law requires that the death certificate be taken signed by the attending physic age 2 should be detached for use as the board.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		ointh 2 ☐ Fet nant at time of	el death 3□	Ectopic pr Other (sp					230	l. Date <i>o</i> f deli Month	ivery Day Year
to the	requires that the top been signed by should be detact	d by Pr	Part II. Other significant condition	s contributing to d	eath but not re	sulting in the u	nderlying c	ause give	en in Part I.			tobacco use	/	the cause of death?
00	VII.dl neCOI.	Completed									24a. Was auto perfe	psy ormed?	death?	itopsy findings available completion of cause of
20	Or VICAL Physician: this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	,	-		Othe		-0-	(Check only	one)		
5.	This aldii	n: To	1 Yes 2 No  27. Manner of Death	28a. Date		28b. Time of Injury		8c. Injun	at at	7	ne 5 🗆 Res 8d. Describe			cify)
Jasuido	tor:	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion		nome, larm, str	M eet. lactor	1 🗆 '	Yes 2 □ No		81. Location (	Street and N	lumber or Ru	iral Route Number.
X	A Hospitel or Ai 24 hours efter of Funeral Directer of tilled in by		4   Homicide	build	ing, efc. (Spec	ify)					City or To	wn, State)		
•	To the Hospitel or At within 24 hours efter or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying 2 Medical E.	Physicien: To the caminer: On the band man	best of my kn asis of examin ner stated.	owledge, death ation and/or in	occurred vestigation	at the tim , in my of	e, date and pointion, death	piace, a occurre	nd due to the id at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier		M				number					n, Day, Year)
	,5		30. Name and address of person w	ho completed caus	se of death (Ite	m 23a) (Type,	Print)	47	76 )			17450	ST 15,	2006
	12		C . A ()	metz m	5 5 2 Registrar's Sign	OUPR	r Ch	esa P	eake E	) rivi	r Bei	l Air,	Md 2	21014
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month ROSINSKY MARYANNE 3:15 **Physician** tugust 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Hospital Ba Hmore City Sihai 01 Bulhmore II Under 1 Year | II Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JULY 31, 1961 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Maryland 1 □ M Director 218-50-5733 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County rthan "netural", or Items 23a or 28a-f show the Medical Examiner royal be notified at 1 ☐ Yes XX No Director Towson Maryland | Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 707 Saylor Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AMNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married Married Specify: White Maryland 21215-0036 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Education Librarian permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any injury or other traumastic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helen Elizabeth Lindenstruth Charles Jacob Smearman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 707 Saylor Court Towson, Maryland 21286 Schim Stanley Rosinsky Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem Gardens 8/19/06 Timonium, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Seryi nnis 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Gastric months /Medical Due to (or as a consequence of): Examiner Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai thet IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) the i 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 1 ☐ Yes 20 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Mnpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OTT August 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jame, Julia 24 MD tospital 31. Date filed (Month, Day, Year) Begistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

6 2006

Mary Resinsty

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** AUGUST 2006 SHORTS 10, 1445 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL GAITHERSBURG MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1⊠M 2□F 49 10-06-1956 WASHINGTON, DC 579-78-7935 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at MD PRINCE GEORGES LANDOVER 1X Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 316 HILLSIDE TERRACE 20785 U.S.A. death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2K No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 3yrs ACCOUNTANT PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be filt Depertment of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic aveni anse Be WILTON SHORTS LUCILLE WEST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 316 HILLSIDE TERRACE LANDOVER, MD 20785 SONJIA SHORTS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State LINCOLN CEMETERY 08-17-2006 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Dheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physicien and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) this certificete hes been signed by the all director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 1 Tes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 □ Inpatient 2 □ EP/Outpatient 3 □ DOA Certification: To 1 ☐ Yes 2X No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1X Natural To tree rivers.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the l 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 10 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BRIAN CARPENTER 9901 MEDICAL CENTER DRIVE ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature AUG 1 6 2006 Registrar

06-05878 Yvonne Sams

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		For State	C C	ertificate o	f Death		g No. 201	6 758
Physician Medical Examine	1/ 🥫 1	Decedent's Name (First, Middle,Las	)	Sams		Date of Death     Month     August 8, 2	Day Year	3. Time of Death 0804 hrs
Hodical Examin		4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, or Location		4c. County of Deat	
		Prince Georges Hospital C			Cheverly	er 24Hrs 8 Date of Birt	Prince George h(MM/DD/YYYY) 9. Bit	
Funeral Director				s last birthday)	Months Days Hours		10 1055 Forei	workshington,
any		Jsual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loca	tion			10d Inside City Limits
* .	۱,	MD Prince	Georges	Landover				1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	D L	10e Street and Number 6703 Vermont Cour	t		10f. Zip Code 20785	10	og. Citizen of What Cou USA	intry?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene in: If item 27 is marked other than "natural", or items 23a or 28a-f shur it if item 27 is marked other than "hatural", or items 23a or 28a-f shur other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Ever in Armed Forces?  1 Yes 2 X N	lf '	as Decedent of Hispanic Ori Yes, specify Cuban, Mexicar  Yes 2 X No specify.	n, Puerto Rican, etc.)	White, etc.	Black
urs afte tural",	⋧┞	Widowed 4 Divorced  15. Decedent's Education (Specify of	If Yes, Give Year or Dates: Ily highest grade completed	) 16a Decede	nt's Usual Occupation (Give	kind of work done	16b. Kind of Business	Industry
1215-0036 Id be filed within 72 hours after Aental Hygiene narked offer than "natural" event, the Medical Examine	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life DO NOT pervisor	use retired)	Privat	e
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2121 uld be fil Mental B marked	e Be	Leroy Sams  19a. Informant's Name/Relationship (1	ype, Print )		Ro ng Address (Street and Nur	mber or Rural Route Num		e, Zıp Code)
nore, MD 2 ages 1 and 2 should nt of Health and N t: If item 27 is nother traumatic	-	Habim Brown/ Son	ı		Vermont Cour			
ore, ME es 1 and 2 s of Health at If item 27 her trauma		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	crematory or o		Date	20c. Location - City o	
= 9 9	Ц	4 Donation 5 Other Specify	R	esurrect	ion Cemetery Name and Address of Facility	08-17-2006		Maryland
Balt permit Departs Import	П	21, Signature of Funeral Service Licer	J. all		7474 Landove:	r Rd., Land	over, MD 20	785
Physician	7	23a. Part I Enter the disease, or comp failure. List only one cuise on e	lications that caused the deach line.	ath. Do not enter	the mode of dying, such as	cardiac or respiratory arri	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic		scular disease			Death
		Sequentially list conditions, b.	Due to (or us a consequent					
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	ce of):				
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760, Icate be physici the buri		IF FEMALE:	23c. If yes, outcome of	regnancy	MF. 0858.8/25/06		23d Date of delive	
Sox 687 death certifit ne attending d for use as t	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of	f doobb	Tetal death 3 Ectop  Other (Specify)	ic pregnancy	Month	Day Year
Box 68 e death certif the attending	Physician	1 Yes 2 No 9 V Unknow	9 OHKHOWH					(1-10
i of Vital Records, P.O. Box 68 ing Physician: The law requires that the death certiff After this certificate has been signed by the attending tuneral director, page 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death but r	ot resulting in the	underlying cause given in P		bacco use contribute to s 2 No 3 Pro	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the ras after death  al Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detach						24a Was		utopsy findings available
e law re has b	ompleted			<del></del>		autor perfo	rmed? death?	completion of cause of /es 2 No
nl Re un: Th rrtificat	Οŀ	25 Was case referred to medical			26 Place of Death	(Check only one)		
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isio	icati	2 Accident Investiga	28e Place of Injury -	At home, farm, st	reet, factory, office building,	etc. 28f. Location (		lural Route Number, City
Divis	Certification:	Suicide 6 Could no determine				or Town, S	State)	
Division o within 24 hours after death within 42 hours after death To the Funeral Director: After completely filled in by the fune	Medical (	29a Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	r:On the best of my known:On the basis of examination and manner stated.	wledge, death occorn and/or investig	curred at the time, date and population, in my opinion, death o	place, and due to the cause occurred at the time, date	se(s) and manner as sta and place, and due to	arted. the cause(s)
To with To com	Me	29b Signature and title of certifier			29c. License numbe	PF	29d. Date signed (M	onth, Day, Year)
4		Panate Trethall	14)		O.C.M.E.		August 9, 2006	
P		30 Name and address of person who Pamela Southall, MD	completed cause of death of Assistant Medical Exa		Penn Street, Baltimo	re, MD 21201		
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature				
Regist	rar	AUG 1 6 2	006 Silver	Di fil	pails			

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) Year 50 Physician 06 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner MORE 1 Baltimore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 23 1912 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 F Months Baltimore, Maryland **219 34 797**0 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r then "natural", or Items 23e or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21234 USA 8830 Walther Blvd. Room 003 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Btack, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: ģ 3√ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
NA Elementary/Secondary (0-12) 12 Assistant Manager Perpetual Savings & Loan . Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant; if item 27 is marked other th jury or othar traumatic event, "III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel M. Schroeder Emma Agusta Hollands 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1378 Summerwood Drive St Thomas, PA 17252 Gale R Loue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc August 14 2006 Baltimore, Maryland 22. Name and Address of Facility at re of Funeral Service Licensee Lassahn Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** meumoura disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months 1 1 Yes 2 No 5 🗌 Other (specify) 4☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed' certificate ? CHF 1 ☐ Yes 2 ☐ No 1 Yes . 2 No 25. Was case referred to medical 26. Place of Death | Check only one Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Accident 5 Pending Injury 2 🗆 No 1 Yes death investigation I Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date sig ed (Month, Day, Year) 1124242 person who completed pause of death (Item 23a) (Type, Print) Buyentho WY) ate filed (Month, Day, Year) 32 Registrar's Signature State 1 6 2006 AUG Registrar

State of Maryland / Department of Health and Mental Hygiene

Registrar

AUGUST

STEINACKER

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ For Stete Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 10:55 P August ,2006 Agnes A. Sansbury /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner les -IMOY 7201 NWO more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

April 17,1913 Washington D.C Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F Yrs. 577-20-5161 April 93 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County s 23a or 28a-1 show 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 709 Maiden Choice Lane Room 116S 21228 IISA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. r than "naturel", or Item the Mudical Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Non Profit Hygiene. Entertainment Coordinator alth and Mental Hygie 27 le marked other t reumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Cordes Clotilda Jahn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Ic any injury or other tre once. 10196 Green Clover Drive; Ellicott City, MD 21042 Richard J. Sansbury Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 8/15/2006 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonville, MD 21228 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diovascular Atherosclerotic years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infrinciplate cause. Enter Underlying Cause (Disease or injury Due to (or as a consecuance of) Examine use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events ding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 Yes 2 The 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? within 24 hours after death, To the Funerel Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Anatural 5 Pending 1 🗌 Yes 2 🗌 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Fo the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Registrar

2006

State of Maryland / Department of Health and Mental Hygiene  $\supseteq \bigcup \bigcup \bigcirc$ 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle, Last) Month Year 12:40 P.M. **Physician** Williams Stanley 2006 Elmer /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner timore Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 3 16 If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1**X** M 2□ F 1925 81 219-18-9173 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Arbutus MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21227 103 Brown's Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: **Black** ₹ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 e filed within 7 at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Post Office Carrier 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill Health and Mental H tem 27 is marked otl Mildred Eley Josuha B. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 102 Brown's Terrace, Arbutus, Md 21227 Frances E. Williams-Wife Pages 1 and 2 ment of Health a ant: If item 27 is Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) permit. Pages Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 8/18/06 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the tilbease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral edema 3 weeks /Medical Due to (or as a consequence of): Examiner carcinomo undetermine Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of) Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Redords, P.C. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete hes autopsy performed? 1 Yes 20No 1 ☐ Yes 2 ☐ No 25 Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No ို 1 Yes 2 ER/Outpatient DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1. Natural 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeret Direct completely filled in by 4 - Homicide ŏ To the Hospitel 29a. Certifier 🖎 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) D0022648 AUGUST 12 ,2006 900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21225 JEROME

Registrar DHMH 17 Rev 1/2001

State

32. Algistrar's Signature

I. SNYDER

AUG 1 6 2006

31. Date filed (Month, Day, Year)

		1 - For State of Registrar	,	artment of Health a	nd Mental Hygie	17002 9007
Physi ି/Med		1. Decedent's Name (First, Middle, Last)  ELIZABETH	MYNN		AUGIVST	Day Year 3. Time of Death 12 2006 5-22 PM
Exam		4a. Facility Name (If not institution, give street and num.  HARBOR HOSPITAL  5. Social Security Number 6. Sex	iber) 7. Age (In yrs. last birthday,	4b. City, Town, or Location of BALILMO	RE 24 Hrs. 8 Date of Birth	4c. County of Death  9. Birthplace (State or Foreign
. Funera Directo		217-22-7211 1 M 2XF Usual Residence of Decedent	84 Yrs.	Months Days Hours	Min. (Month, Day, Ye	22 Country) SC
he Marylar 28a-1 show	ector	10a. State 10b. County  MD Anne Arunde  10e. Street and Number	1 10c. City, Town or L	en Burnie	100	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Citizen of What Country?
Ind 21215-0036  be filed within 72 hours after death with the Maryland hat hygiene. In hygiene. In other than "netural", or Itams 23a or 28a-1 show event, the Medical Evanther must be retilled at	by Funeral Director	6508 Jefferson Place	2 <b>X</b> No	21061 Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,  1 Yes X No Specify:		U • S • A •  14. Race - American Indian, Black, White, etc.  Specify: Black
nd 21215-0036 e filed within 72 hours af al Hygiene. other than "netural", or vant, the Medical Event	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10th grade  15. Decedent's Education (College (1-12))  College (1-12)  na	(Give	edent's Usual Occupation e kind of work done during most DO NOT use retired) Housewife	of working	Example 1. Control of Business/Industry
Maryland 2 nd 2 should be filed tith and Mental Hygi 27 is marked other r traumatic evant, I	To Be C	17. Father's Name (First, Middle, Last)  William Todd  19a. Informant's Name/Relationship (Type, Print)	19b. Mail		r's Name (First, Middle, Mai Lie Todd r or Rural Route Number, C	
ore, es 1 ar of Hea of Hea of Hea		Vivian Creek-Daughte 20a. Method of Disposition  1X□ Burial 2 □ Cremation 3 □ Removal from S  14 □ Donation 5 □ Other (Specify)	20b. Place of Disp	Hanmonds La osition (Name of ematory or other place)	ne, Baltimo	
Baltime permit. Page Department Important: Il any injury o		21. Signature of Puneral Service Licensee	. 2	12. Name and Address of Facility	1	
Priysicial /Medica Examine pu	đ i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (in the cause of the ca	nest line.  MESTIVE Por as a consequence of):  SEPSIS	NEART FAIL  THE FAILVE	URE EXF	Approximate Interval Between Onset and Death A CERBATION 2 WEEKS 2 WEEKS
68760, rificate be executed g physician and as the burial-transit	ical	d. T	or as a consequence of): SCHEMIC	COLITIS		2 Weeks
P.O. BOX 687 that the death certificate of by the attending phys detached for use as the	Physician/Med	in the past 12 months?	ant at time of death 5	□Ectopic prøgnancy □ Other (specify)		23d. Date of delivery Month Day Year
ecords, P.O. law requires that the as been signed by the 2 should be detache	b	Part II. Dther significant conditions contributing to de DILATED CARDIOM	HOPATHY	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
The ate h	Completed	ATRIAL FIBRILLA			24a. Was an autopsy performed 1 Yes 2	
ing Phys Mer this	Certification: To Be	27. Magner of Death    Natural   S   Pending   (Monti	h, Day Year) Injury	ont 3 DOA Other: 4 Nur of 28c. Injury at Work? M 1 Yes 2 N		
pitel or curs afte caral Dir	dical Certif	4 Homicide determined building		th occurred at the time, date and	City or Town, S	e(s) and manner as stated.
To the Hos within 24 h To the Fur completely	Medic	29b. Signature and title of certifier	er stated.	29c. License number	29d.	Date signed (Month, Day, Year) UNST 12 2006
2	tate	<i>19</i> .		Print) OVER ST,	BALTIMOR	RE MD
Regi	strar	AUG 1 6 2006	Ever St. R.	and the second		

			1 - For Amend #3 Sta	te of Maryland / Dep r Phy G858 8 167 Cei	ortment of Health and No. The control of the contro	lental Hygien Reg. N	2006 2582	2
5	Physici		Decedent's Name (First, Middle, Last)  LOIS MAE WHIT'			2. Date of Death	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street a 3815 - 37th St	reet	4b. City, Town, or Location of Death Mt. Rainer, MD  If Under 1 Year   If Under 24 Hrs.	4	c. County of Death P.G.	
	Funeral Director		5. Social Security Number 2.13−14−7063 6. Sex 1 □ M 2 2 2 2 2 2 3 - 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	7. Age (In yrs. last birthday) 92 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 22,	9. Birthplace (State or Fore Country) Phila., PA	ngn
	within 72 hours after death with the Maryland ane. than 'natural', or Itams 23a or 28a-f show ta M. vical Exa. illust i, ust be notified a	ector	MD P.G.	Mt. Raine		100.0	10d. Inside City Lim  X□Yes 2□!  Citizen of What Country?	
	ath with I	Funeral Director	3815 - 37th Street		20712	τ	JS	
036	be filed within 72 hours after death with the Marylan ital Hygliene. Id other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, the Modical Exacultur man be notified at	þ	1 Never Married 2 Married 1 If Y	ned Forces? 1Yes 2/2No	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black	
1215-0	within 72 ho lene. then "natur	Completed	15. Decedent's Education (Specify only highest grade comp Elementary(Secondary (0-12) 11th Col	leted) (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) Homemaker	ang	Kind of Business/Industry  Lf Employed	
Maryland 21215-0036	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  John T. Handy		Cora Fit	e (First, Middle, Maide Chett	ən Sumame)	
a)	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationship (Type, Pri.  Helen Whittington/Daug  20a. Method of Disposition  1△ Burial 2 □ Cremation 3 □ Remova  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Light e	thter 12 Wood cemetery, creating John West	natory or other place) Ley Cemetery 8/05 2. Name and Address of Facility Fra	kesville Date 20c. 0/06 Mar azier's Fur	MD 21208 Location - City or Town, State Lion, Maryland	2000
	Physician and /Medical Examiner and physician support in the primary in the prima	Examiner	S. quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	tue to (or as a consequence of):  H C	att u UL	or respiratory arrest,	1 du 20 /eu	Y
O. Box 68760,	death certifi e ettending id for use as	Physician/Medical	in the past 12 months?	es, outcome of pregnancy	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year	73
s, P	The law requires that the do ate has been signed by the bage 2 should be detached	þ	Part II. Other significant conditions contribution	ig to death but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?	
of Vital Record		Completed	n l zhei	me/		24a. Was an autopsy performed?	24b. Were autopsy findings availal prior to completion of cause of death?  1  Yes 2 No	ble of
ion of Vita	Attending Physicien: r death. ector: After this certific by the funeral director.	tlon: To Be	25. Was case referred to medical examiner?  1	1   Inpatient 2   ER/Outpatier Date of Injury (Month, Day Year)   28b. Time of Injury	nt 3 DOA Other: 4 Nursing Ho	ome 5 Residence 28d. Describe how in		
Division	tel or Attendi s after death. al Director: A sed in by the fu	Certification:	a □ Cuitada 6 □ Could not be	Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ite)	
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in D	edical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, deat the basis of examination and/or in d manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	s) and manner as stated. nd place, and due to the cause(s)	
	To the within 2 To the complet	Σ	7,611,75	HAI, NALNI	0373/0		Date signed (Month, Day, Year)  Ry 31 2006	
	Sta Registi		30. Name and address of person who complete RASHID BAGHAI 344  31. Date filed (Month, Day, Year)		l., Silver Spring,	MD 20910		

		For State Registrar	State of I	Maryland /		artment of I		and Me		iene eg. No.	006	25823
Dhyei	ion	1. Decedent's Name (First, Middle	e, Last)				_	2	Date of Dea Month	th Day	Year	3. Time of Death
Physi /Med			. Wilson			T			ugust	12	2006	
Exam	iner	4a. Facility Name (If not institution	•	er)		4b. City, Town, o					unty of Death	
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Funera Directo	_	338-26-4348 Usual Residence of Decedent	1 <b>⅓</b> M 2□F	73	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day une 12	, 193	3 I11	intry) inois
yland how		10a. State 10b. County		10c. City, To	own or Lo	ocation						10d. Inside City Limits
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with th	Dire	10e. Street and Number				10f. Zip Code			1	0g. Citizer	of What Cou	untry?
eath v	era	221 / O1d F:	rederick Ro		13		21228	ain? (Specif	v Ves or No-	14	USA Race - Arner	ican Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: if Item 27 is marked other then "naturel", or Items 23s or 28e-1 show eny injury or other treumstile event, the Medical Exampler must be marified at	by Funeral Director	1 ☐ Never Married 2 🔀 Marr	Armed Force  1 Yes 2  If Yes, Give	es? ☑ <b>X</b> No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No			can, etc.)		Black, White	
21215-0036 soft within 72 hours aff giene. or then "naturel", or the Medical Exam.	q pa	3 Widowed 4 Divorced	Year or Date		6a Dece	dent's Usual Occu	nation				of Business/l	adustav
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Maryland nd 2 should be file lith and Mental Hy 27 ie marked oth	V .	19a. Informant's Name/Relations				ng Address (Street				-		
e, No 1 and		Suzanne R. W. 20a. Method of Disposition	ilson -	Wife 20b Place		7 Old Fre		k Koa Dat			ion - City or 1	
Baltimore, permit. Pages 1 a Department of Hea Importent: If Item		1 ☑ Burial 2 ☐ Cremation		118		osition (Name of matory or other pla						Maryland
Iting iii. Paratme	٠	4 □Donation 5 □ Other (S 21. Sign tre of Fit al Service	1	Lake		Mem. Par						
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Physicia		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	h line.	Do not en		ng, such as	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
/Medica Examine		resulting in death)		as a consequen								
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68760, tificate be exe g physicien a as the burial-	dlcai		d			·						
I Records, P.O. Box 68  The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the set of th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal de	ath 3[	⊒Ectopic pregnand	:y			230	I. Date of deli	very Day Year
.O. Ithe dear the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□ Unknow	t at time of death	n 5[	Other (specify) _						
dS, P.  irres that signed by d be deta	d by P	Part II. Other significant condition HYPERTENSION				Inderlying cause gr	-		23e. Did to	V		the cause of death?
v requ	ete	1, 3,3	, , , ,	/					24a. Was a			opsy findings available
I Re la The la ate has page 2	Somp								autops perfor	sy	prior to c death?	ompletion of cause of
f Vital F yslcien: Th is certificate director, pag	Be	25. Was case referred to medica examiner?						of Death (	Check only or	10)		
Of Physic this caldir	J.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inp.		Outpatie	IN 3LI DOA			5 Resident			afy)
on of ding Phy h. After thi funeral	tion	1 Natural 5 ☐ Pendir		Day Year)	Injury	Wo	rk? ]Yes 2∐!		a. Describe in	Jw injury 0	CCUITEG	
IVISI r Atten er deat rector:	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At home , etc. (Specify)	, farm, st	reet, factory, office			Location (S City or Tow		lumber or Ru	ral Route Number,
Durs aft	Cer	V										
Division of Vita Vita No. 10 to 10 t	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basi and manner	est of my knowle is of examination r stated.	dge, deat and/or in	th occurred at the to	ime, date an opinion, dea	id place, and th occurred	d due to the c at the time, d	ause(s) an ate and pl	d manner as ace, and due	stated. to the cause(s)
To the within To the comple	×	29b. Signature and title of control	г			29c. Licen		,	2		igned (Month	
_		1 /Jm	رسار				8290			AMG	ust 1	4,2006
10		30. Name and address of person	BBONS, M	of death (Item 23	Ba) (Type,	Print) EK BROW!	J RD.	Sur	n= 201	, ELI	KRIDGE	2015 AM
Regi	tate trar	31. Date filed (Month, Day, Year) AUG 1 6	2006 Reg	istrar's Signature	An	roles						75015 DW

			For State Registrar	of Maryland		artment o			nd Me		giene	006	25824	
Physici /Medic Examin		an	1. Decedent's Name (First, Middle, Last)  Herschel Clayton			wygrer				2. Date of Death Month Day Year August 11, 2000		OX.	3. Time of Death 3:16 P M	
		er	4a. Facility Name (If not institution, give street and number)  5. Social Security Number  6. Sex  7. Age (In yrs. last bit)			4b. City, Town, or Location of Death  WCS 1m NS  If Under 1 Year   If Under 24 Hrs.    Months   Days   Hours   Min				8. Date of Birth 9. Birth			place (State or Foreign	
P	should be filed within 72 hours after death with the Maryland on the Maryland of the Maryland of the Maryland of the Maryland of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland Examination of the Maryland of the Maryl	Completed by Funeral Director	218-07-6061 VIM 2 F 91 Yrs. Months Days Hours Min. Month Pay Year, 1915 County 1 and Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits											
h the Maryla			Maryland Carroll  10e. Street and Number		nchester					1 ሺ Yes 2 ☐ No				
16 after death wit			1 Never Married 2 Amed 1 Yes	ecedent Ever in U.S. Forcas? S 2 No Give		Was Deceden f Yes, specify			in? (Spec Puerto Ri	ify Yes or No- ican, etc.)	14. [	S.A.  Race - Americ Black, White,	etc.	
Maryland 21215-0036			3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)									Specify: White  6b. Kind of Business/Industry  Blade Sharping		
yland 2		To Be Co	17. Father's Name (First, Middle, Last)  Marshall Clayton Wagne	r	061.	L ABILLY C		18. Mother		(First, Middle, Virgin	Maiden Sun	name)	r.Dr.ms	
, Mar and 2 sho			19a. Informant's Name/Relationship (Type, Print) Julia Wagner – wife		3335	Locust	St.	. Han	chest	Route Numbe	. 2110	02		
Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)		Luthe		em.	Aug.		2006	Mancl		, Md.	
Ball			21. Signature of Funeral Service Licensee  Schlaff of Funeral Chapel P.A.  3296 Charmil Dr. Manchester, Md. 21102											
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certification on post of the funeral director.	Medical Certification; To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death Minutes  Due to (or as a consequence of):								Interval Between Onset and Death			
E			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	nce of):  nce of):	of):									
P.O. Box 68 nat the death certifical			in the past 12 months?	las decedent pregnant    the past 12 months?							23d. Date of delivery Month Day Year			
Records, P.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4								he cause of death? pably 4 Unknown			
E F			25. Was case referred to medical					24a. Was an autopsy performe 1 ☐ Yes 2 € 26. Place of De ath (Check only one)			med2 2 No			
P. O.			examiner? 1   Yes 2   No							Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
Division			2 Accident investigation		M 1 Yes 2 No					treet and Nu n, State)	et and Number or Rural Route Number, State)			
Hospite			29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Toth			29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29t. 151 2000									Day, Year)		
-	1,3		30. Name and addres person who completed cause of death (Item 23a) (Type, Print)  Jan C. Mel Mo 2955 P ner Are: 5v/R 307 vr3/minster MD 21157											
	Sta Registr	5.00		Registrar's Signatur		uke								

DHMH 17 Rev 1/2001

ORIGINAL

Please	Type or	Print	in Black	Indelible ink.	Ensure All Copies Are	Legible
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			For State Registrar	State of Maryla		artment of F rtificate of			giene Reg. No. 200	i	25825
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		ear	3. Time of Death
	Physici: /Medic		SAMARAKOONGEDARA	A FRANCIS	WIJ	ERATNE		August	10 000		9:00 A. <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death		4c. County of	Death	
			115 W. Seminary A	venue			erville		Balti		
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 9	h year) 9	Count	ace (State or Foreign ry)
	Director		310-90-4000 -	<sup>™ 2□ F</sup> 53	Yrs.			Jan. 9	, 1953   8	rı l	lanka
	and * _		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10	d. Inside City Limits
	daryl f sho	ō	Maryland Baltimo	re	Lutherv	rille					1 ☐ Yes 2 💢 No
	the the 28a-	Director	10e. Street and Number	10	Ducher	10f. Zip Code			10g. Citizen of Wh	at Count	ry?
	Sa or	ā	115 W. Seminary A	venue			21093		Sri L	anka	a.
	Jeath Tra 2:	Funeral		12. Was Decedent Ever in	n U.S. 13.	Was Decedent of H	dispanic Origin? (Sp	ecify Yes or No-	14. Race -	America	n Indian,
CO.	of the	F	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No		1 ☐ Yes 2 X No	an, Mexican, Puerto  Specify:	rican, etc.)		White, e	
Š	ralf, c	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 1 1 63 2 QA 1 1 0	эрвену.		Specify:	Asi	an 
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation e co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Busin	ness/Ind	ustry
7	ithin Ben Ben	npi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			Mod	ical	
2	be filed within 72 hours after death with the Maryland hat Hygiene. d other than "natural", or Itama 23e or 28e-f show event, I're Madical Exercites most be notified at		17. Father's Name (First, Middle, Last)	5+ years	K	egistered		e (First Middle	Maiden Sumame)	ICal	
and	tall H	Be						11.			
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	2	Juan Appu  19a. Informant's Name/Relationship (Ty	ne Printl	19b. Maili	ng Address (Street	Augusti		Haami. er, City or Town, St	ate, Zip	Code)
S	d 2 s th an 17 is trau		Ellen Wijeratne	(wife)	115 t	J Semina	ry Ave. I	uthervi	lle Mar	√lan	d 21093
	1 and 2 Health Iem 27 other tra		20a. Method of Disposition			osition (Name of matory or other pla		Date	20c. Location - Ci		
<u>o</u>	Pages nent of int: If it		1 M Burial 2 □ Cremation 3 □ P 1 1 Donation 5 □ Other (Specify)	temoval from State		oh Church		L9 <b>-</b> 06	Cockeysy	ille	e, Maryland
Baltimore,	그 본문을 .		21. Signature of Funeral Service License				wiedefeld				,j
B	Depariment impo		Heman A Fe	Marzo.	19	500 York	Road Ba	ltimore	, Marylan	$d^{21}$	212
	A		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the d	eath. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ardeniosa	antic	Cardiovo	iscular 1	Seasi			Onset and Death
	/Medical		resulting in death)	Due to (or as a con		-001-0-0				7	-
	Examiner		Commentally list conditions	D							
7	B ==	ner	If any leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):						
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	0.							
8760,	death certificate be executed e attending physician and of for use as the buriat-transit		1030king in Godkin 2234	Due to (or as a con	sequence on).						
87	physic	dical		d							
9	death certifica attending phase as to	d)	IF FEMALE:	23c. If yes, outcome of pre	onancy				23d. Date	of delive	nv.
Вох	atten for us	Physician/M	in the past 12 months?	1 Live birth 2 □ F 4 □ Pregnant at time	etal death 3	□Ectopic pregnanc □ Other (specify) _	:y		Month Month		Day Year
o.	that the deatt ed by the atte detached for	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	or dod!!!						
م.	es that the igned by th be detache		Part II. Other significent conditions con	ntributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Did to	obacco use contrib	ute to th	e cause of death?
sp.	.≒ × ₽	d by						10	Yes 2□No 3	☐ Proba	ably 4 Unknown
Records	> 11 (A	Completed						24a. Was	an 24b. We	ere autop	sy findings available
Re	0 - 0	dmc							rmed? de	ath?	npletion of cause of
Vital	ician: Th certificate rector, pag	Ö	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes			205110
	8 V F	0 B	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Ot	har	152	dence 6 Other	(Specify	)
0	g Phy er thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time	of 28c. Inju	ry at	28d. Describe I	how injury occurred	i	
jo	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation				Yes 2 No				
Division of	er de recto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, s	treet, factory, office		28f. Location (3 City or Tox	Street and Number wn, State)	or Rurai	Route Number,
	ital or rs afte ral Dir			1							
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	cai	(Check only 2 Medicel Exami	rsician: To the best of my iner: On the basis of exar	knowledge, dea nination and/or i	th occurred at the to nvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and many date and place, an	ner as sta d due to	ated. the cause(s)
	To the within 2. To the complet	Medicai	29b. Signature and Atle of certifier	and manner stated.		29c. Licen	se number	· · · · · · · · · · · · · · · · · · ·	29d. Date signed	Month, L	Day, Year)
	wit To		Later H. MA	Golf d	L	NI	81.17		1 . + 11		
,		6	30. Name and address of person who c	ompleted cause of doort	(Item 23a) /Tuna	Print)	0461	Į į	tuing 1	1,20	306
	3		Philip Militell		4 1	17:11 CT	Luthervill	am 9	21092		
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature			1 -	* ***		
20	Regist		ALIC 1 C 200	16	H A	and !					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6:16 P **Physician** 3 2006 ROSCOE ROBERT YOUNG /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BACTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) HOSPITAR 17 An (3000) N/A SAMAR 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) 6. Sex **Funeral** Days Hours Months 1⊠M 2□F Yrs JULY 24 1945 MARYLAND Director 216-42-1508 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r than "natural", or Items 23a or 28a-f shov the Medical Exempler must be mutified at 1 X Yes 2 □ No Directo MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3723 REISTERSTOWN ROAD Funeral 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: BLACK ፩ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Mudical Exp. 2006. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade UNEMPLOYED N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ROSCOE R. YOUNG ELEANORA GROSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanora Gross/Mother 3723 Reisterstown Rd., Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tySurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 08-18-06 PARKVILLE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signatore of Funeral Service Agens Warn 1206 W. North Avenue Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner STAG Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit requires that the death certificate be executed ENM resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 ☐ NO 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOD62239. DR MALU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Husnita Samaretan 200d 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 1 6 2006 Registrar

			For State Registrar	S	tate of	Marylan		artment rtificate					g. No.	006	258	
	Physici	an	1. Decedent's Name (First, Midd Joseph Charl		h1. S	r.						Date of Death Month August	Dav	Year 2006	3. Time of 6:05	
	/Medic	al	4a. Facility Name (If not institution					4b. City,	Town, or	Location of		August	1	ounty of Death	0.05	
	Examin	er	8925 Chapel					E11:	icot	t Cit	у			Howa	rd	
	Funeral Director		5. Social Security Number 219–34–1847	6. Sex 1 🔯 M	7	. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	8 dim	Date of Birth (Month, Day, ept. 15	γ <sub>θ</sub> ar) , 19	9. Birthr Coul 38 Mary	place (State ontry) (Land	or Foreign
	pc .		Usual Residence of Decedent			10c Cit	y, Town or Lo	eation							IOd. Inside C	ity Limits
	aryla •hov	ក					•								1 🗆 Yes	
	28a-f	ect	Maryland Howar	:d	. "	EII	icott	10f. Zip	Code			10	g. Citize	n of What Cou	ntry?	
	3a or	Funeral Director	8925 Chapel Av	enue				2	1043				USA	A		
	death	nere	11. Marital Status	12.	Was Deced	lent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Orig n, Mexican,	in? (Specif	y Yes or No- an, etc.)	14.	Race - Americ Black, White,		
21215-0036	72 hours after death with the Maryland "natural", or Iteme 23s or 28s-f ehow colcal Examinat must be notified at	Ď	1 ☐ Never Married 2 反 Ma. 3 ☐ Widowed 4 ☐ Divorce	ried	l □Yes 2 If Yes, Give Year or Da	2 ⊊No		1 ☐ Yes					Sį	pecify: Wh	ite	
5-0	22 8 3	Completed	15. Deceder (Specify only higher				(Give	dent's Usua kind of wor	rk done a	luring most	of working	1	6b. Kind	of Business/In	dustry	
21	d within giene.	훁	Elementary/Secondary (0-12)	Ť	College (1-	4or 5+)		DO NOT us				11	S	Govern	nont P	rintir
			11 17. Father's Name (First, Middle	Last)			В	JOK D.	liide		r's Name (F	First, Middle, M			nent i	LIIICII
Maryland		To Be	George G. Zahl							Marga	aret S	Starkla	uf			
lary	2 sh and is m		19a. Informant's Name/Relation			wife								own, State, Zij Maryla		143
	1 and Health em 27 ther to		Elizabeth B. 2	Lanı		20b. F	Place of Dispo	sition (Nan	ne of	-	Date			tion - City or To		
Baltimore,	permit. Pages Department of H Important: if its any injury or of		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		oval from S	tate I	emetery, cres dours i d				/17/2	006 E	lkria	dge, Ma	rv1and	
量	with Point P		21. Signature of Funeral Service		V		2	2. Name an	d Addres	s of Facility	Ster	ling As	hton	Schwal	Witz	ke
ñ	Den Pen Pen Pen Pen Pen Pen Pen Pen Pen P		1 EMI	21	K	M		runera 1630 E	ai no Edmoi	ome oi ndson	Aveni	onsvill ie: Cat	e, 1 onsv	nc. ille, l	MD 212	28
	Physician /Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or confiblication to only one confibrition as	Due to (c	eu wanter as a consection	100	ter the mod	e of dying	g, such as d	cardiac or ri	espiratory arre	st,			ween
3760, K	death certificate be executed e ettending physicien and d for use as the burral-transit	Ical Examiner	Sequentially list conditions, if cay, leading to inniculate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b c. d.	Due to (c	c as a consec	e c	eu o	J							ear
.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c.	1 Live bi	come of pregnanth 2 ⊡ Feta ant at time of co	al death 3	☐Ectopic pr ☐ Other (sp					23	d. Date of deliv Month		Year
ds, P	luires that n signed b	ě	Part II. Other significant condit	ions contrib	uting to de	ath but not res	sulting in the u	ınderlying c	ause givi	en in Part I.			acco use s 2 🗆	contribute to the No 3 Pro		death? Onknown
Il Records,	: The law requires that the sete hes been signed by the page 2 should be detache	Completed										24a. Was ar autops perform 1 Yes 2	/	24b. Were autoprior to condeath?	ompletion of o	available cause of
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medic examiner?	al Hosi	oital:				Oth			Check only on		70" (0		
ō	Phys this ral dii	lon: To	1 Yes 2 No  27. Manne Death  1 Natural 5 Pend	ing	1 ∐ II 28a. Date o		ER/Outpatie 28b. Time o Injury		28c. Injun World	4 🗆 1401	280	d. Describe ho		⊡Other (Speci occurred	<i>iy)</i>	
Division	ter deet irector: by the	Certification:	3 ☐ Suicide 6 ☐ Could	tigation I not be mined	28e. Place buildin	of Injury - At h ig, etc. (Speci	ome, farm, st					f. Location (Sti City or Town	reet and i	Number or Rui	ral Route Nur	nber,
_	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in the completely	Medical Ce	29a. Certifier 1 Certify (Check only one)	ing Physici I Examiner	an: To the : On the ba	sis of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tin	ne, date and pinion, deat	d place, and th occurred	d due to the ca at the time, da	use(s) a	nd manner as lace, and due	stated. to the cause(	s)
	ithin the other	Mec	29b. Signature and title of certif	ier	una mam			29	c. Licens	e number		25	d. Date	signed (Month	Dey, Year)	
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~	41		30. Name and address of person	n who comp	letericaus	e of death (Ite										
	()		L. Austro Do	le me	Gre	eurebay				les, 2	25.0	Treens,	54.,	Balten	וא ניצע Mi	0 21201
		ate	31. Date filed (Month, Day, Yea		le C	egistrar's Sign	ature	noute	,							
Ŷ	Regist	rair	Aug 1	b ZUUb	Sec.	market .	15. 15%	NEW SE								

Francisco Humberto Arqueta

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg No Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 25, 2006 2000 hrs Francisco Humberto Argueta Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Bladenburg 4911 Taylor Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign F.1 S.a.1 If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Foreign El Salvado
Country) Months Davs Hours Director 44 10/<del>01/</del>1961 1 X M 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Maryland P.G. Bladensburg Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4911 Taylor Street 20710 Salvador Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married Married 2 X No Yes 1 X Yes 2 No specify: Salvadoran Specify. White 4 Divorced If Yes, Give Year "natural", 3 Widowed þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it: If item 27 is marked other than other traumatic event, the Medical 21215-0036 Compl Custodian Eleven. 9th of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be un-known Jūana Argueta Rodriguez 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ပ္ Baltimore, MD Ofelio Vigil / friend Bladensburg, Maryland, 20710 20c Location - City or Town State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State San Salvador Family Cemetery Aug.1,200dEl Salvador'
.H. Bacon Funeral Home, Inc. Donation 5 Other Specify: 0. permit 22. Name and Address of Facility W. H. 21. Signature of Funeral Service Licensee 3447 14th Street, N.W. Washington, D.C. 20010 that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complications **Physician** Between Onset and failure. List only one cause on each line. /Medical a. Electrocution Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Cis-ess or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transi Physician/Medical 8per fh g859 9-21-06 vt X AMENDED UNPENDED attending physician for use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, P. Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Sublject electrocuted while installing exhaust fan Certification **FOUND** Natural 1 Yes 2 V No Pending within 24 hours after death Fo the Funeral Director: Jul 25, 2006 1630 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4911 Taylor Street, Bladensburg, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) July 26, 2006 O.C.M.E. 30. Name and address of person who completed cause of ceath (Item 23a) Assistant Medical Examiner Theodore M. King, Jr., MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day Year) Registrar's Signature State Registrar ORIGINAL DHMH 17 Rev 1/2001

		_	For State Registrar		State of M	Marylan	•	artment of I rtificate of					16	25829
	Physici /Medic		1. Decedent's Nam		ALBRIGHT,	SR.					2. Date of Dea	_	<b>06</b> °	3. Time of Death 9:30PM M
}	Examin			If not institution,	give street and numbe	or)		4b. City, Town,	or Locatio	n of Death		4c. County	of Death  LBOT	
	Funeral Director		5. Social Security 1 212–30–4	1111	6. Sex 7. /	Age (In yrs. <b>73</b>	last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. s Min.	8. Date of Birt (Month, Da JAN 11	h y. Ye <i>ar</i> ) 1933	9. Birthp Coun MAR	elace (State or Foreign htry) YLAND
	yland yland		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Limits
	ith the Marylar or 28a-1 show se notified at	ctor	MD	]	CALBOT		Е	ASTON						1 ☐ Yes 2X No
	h with th	al Dire	25790	imber ROYAL OA	K ROAD			10f. Zip Code	1601			10g. Citizen of V		ntry?
980	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hygiene. itiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, II a Medical Examinating to notified a	by Funeral Director	11. Marital Status 1 Never Mar 3 Widowed	ried 2 Marrie	12. Was Deceded Armed Force ad 1 (AYes 2 [ If Yes, Give Year or Date:	s? ∃No		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 XNo			ocify Yes or No Rican, etc.)	- 14. Raci Blac Specify	k, White,	
215-0036	withle 72 ho ene. thsn "natu ne Medical	Completed	(Spe		s Education grade completed) College (1-4c	or 5+)	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	during m ed)	ost of worki	ng	16b. Kind of Bu	siness/Ind	dustry
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	and 2 sho salth and n 27 Is mu		19a. Informant's N	lame/Relationsh <b>ALBRI</b>				ng Address (Stree 90 ROYAL						Code)
lore,				☐ Cremation	3 □Removal from Sta	te C	Place of Dispo cemetery, crea	sition (Name of matory or other pla	ace)	D	ate	20c. Location -		own, State
Baltimore,	permit. Page Department of Important: If any injury or once.		° 4 ☐ Donation 21. Signature of F	5 □ Other (Sp uneral Service L	icensee		22	LLL CEME' Name and Addr	ess of Fac	cility				RYLAND
8	88 = 88		Joseph	30.6	Ostrausk' (complications that caus		120	ELLOWS, 1	RRISC	N ST	EASTON,	MD 216	RAL I	
	Physician /Medical Examiner	1	shock, or he- Immediate Cause disease or conditi resulting in death) Sequentially list of if any, leading to it	art failure. List o (Final on	aue to (or ab)	or line.  CCCC  as a conseque	HC (	ancer			i rospitatory at	1031,	\ />	Approximate Interval Between Onset and Death
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Il Records,	The ate h	Completed					<del> </del>				24a. Was autop perfo 1 \( \text{Yes} \)	med?	rior to cor leath?	psy findings available inpletion of cause of
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	Jing After fune	atlon: To	1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☑ Natural 2 ☐ Accident		28a. Date of li (Month, i		28b. Time of Injury	f 28c. Inju Wo	ury at ork?	2		dence 6 □Othe now injury occurr		/)
Division	al or Attenos s after deatl al Director; ed in by the	Certification:	3 Suicide 4 Homicide	6  Could n determin	and 289. Place of	Injury - At he etc. <i>(Specif</i>		eet, factory, office		2	28f. Location (5 City or Tox	Street and Numbern, State)	er or Rura	l Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier (Check only one)	1 ■ Certifying 2 ■ Medical E	Physician: To the be examiner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date opinion, d	and place, a leath occurre	and due to the ead at the time,	cause(s) and ma date and place, a	nner as st	ated. the cause(s)
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8	+1 40				no completed cause o				)N M	ARVI AN	VID 2160	1		
	Sta Regist		31. Date filed (Mo	JUL 2	2008 32.	strar's Signa	ature /	Sold Sold	רו פוני	OK I IV	4D 2100	1		

			For State Registrar	State of		nd / Dep	artment of H	lealth and	•			25830
	Dhysisi		1. Decedent's Name (First, Midd	dle, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio Examin	al	MARIAN 4a. Facility Name (If not institution	LEE on, give street and num		REE	4b. City, Town, or	Location of De	07	25	2006 County of Dea	1:45 P <sup>M</sup>
			Caroline _	l <u>o</u> spice			Dento	ñ		(	Carolin	e
	Funeral Director		5. Social Security Number 214-32-1734	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 72	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		ay, Year)	C	thplace (State or Foreign ountry) ryland
	and and		Usual Residence of Decedent  10a. State 10b. Count	у	10c. Ci	ty, Town or L	ocation	-				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	ţō	Maryland Card	oline	R	idgely						1 Yes 2 □ No
	or 28	Completed by Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What C	ountry?
	ath w	ral	P.O.Box 292				21660			UŞA		
	ter de Itams Irer	une	11. Marital Status  1 ☐ Never Married 2 ☐ Ma	12. Was Dece Armed For 1 Tyes	ces?	I.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	)-	4. Race - Ame Black, Whi	
215-0036	urs af	by	3 X Widowed 4 □ Divorce	IT YAS GIVE	• •		1 ☐ Yes 2 🔼 No	Specify:			Specify:	lack
2-0	72 ho	ted	15. Decede	est grade completed)		16a. Dece	dent's Usual Occup	ation	warking	16b. Kir	nd of Business	
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121	filed within Hygiene. other than sent, Inc. Man.		11. Father's Name (First, Middle	a (ast)		LIne	Worker	18 Mother's N	lame (First, Middle		en Food	S
Maryland	Mental harked of	o Be							, , ,		Surname)	
J.	2 should and Men Is marke aumatic	ဥ	Clarence 19a. Informant's Name/Relation	Acree nship (Type, Print)		19b. Maili	ng Address (Street	Berni and Number or			Town, State,	Zip Code)
	alth a alth a 27 is		Elva Bernice	Acree/ Dau	ghter	2242	9 Hillsbo	ro Road	, Denton	,Mary	land 2	1620
ore,	es 1 and 2 of Health f Item 27 I		20a. Method of Disposition 1		20b. F	Place of Dispe	osition (Name of matory or other place		Date		cation - City or	
Ë	Pag ment ant; I		'4 □Donation 5 □Other (		- 1	ring G	rove Cem.	08-0	5-2006	Dent	on,Mar	yland
Baltimore,	permit. Pages 1 Department of H Important: If Itel any Injury or ott		21. Signature of Fundinal Service	e Licensee		2	Name and Address Bennie St 426 Dove				vland 2	21601
	H		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that ca st only one cause on ea	used the deat ich line.	th. Do not en						Approximate Interval Between
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1	/Medical Examiner		resulting in death)	Due to (d	or as a consec		1 PARENTE					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (d	or as a consec	quence of):						
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3760,	ate be executed physician and the burial-transit	Icai		d								
x 68	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Med	IF FEMALE:									
Box	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		ome of pregnath 2 ☐ Feta ant at time of c	al death 3[	Ectopic pregnancy Other (specify)			2	3d. Date of de Month	livery Day Year
0	that the de sed by the a detached f	yslo	1 □ Yes 2 2 No 9 □ Unknown	9□ Unkno		reatin 5t	Citier (specify)					
٥	The law requires that the ate has been signed by th page 2 should be detache	by Pr	Part II. Other significant condit	tions contributing to de	ath but not res	sulting in the u	inderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death?
Records,	w require been sig should be	ed b			<del></del>				10	Yes 2	(No 3□P	robably 4 DUnknown
တ္ထ	law re	piet							24a. Was		24b. Were a	utopsy findings available
Ä	stctan: The law certificate has b irector, page 2 s	Completed							auto perfe	ormed?	death?	completion of cause of
Vital	clan: ertific ector,	Be	25. Was case referred to medic examiner?						eath (Check only	one)	Street .	
of	this ald	2	1 Yes 2 No			ER/Outpatie		4 140121116	Home 5 ☐ Res			icify)
on	ng fte ne	tion	Natural 5 Pend	28a. Date o (Monti	Day Year)	28b. Time o Injury	Worl	/at k? Yes 2 □ No	28d. Describe	now injury	occurred	
Division	Attending in death.  actor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	d not be 28e, Place	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location (	Street and	i Number or R	ural Route Number,
ă	al or a after	Certification;	4  Homicide Geter	buildin	g, etc. ( <i>Speci</i> i	fy)	•		City or To	wn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier 1 Certify (Check only 2 Medics	ing Physician: To the al Examiner: On the ba and mann	sis of examina	owledge, deal ation and/or in	h occurred at the tin evestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the curred at the time,	cause(s) date and	and manner a place, and due	s stated. e to the cause(s)
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	0/		30. Name and address of perso	n who completed cause	,	, , , , ,	*				1	l
	0		Mary S. DeSi	nields, M.D	. 401 gistrar's Signa		rce Stree	t,Suite	101, Ea	ston,	Maryla	nd 21601
	Sta Registi		31. Date lied (Month Say & e)	2006	gistral s Signa	G A	2					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Harriet Ball July 26 2006 13:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Fort Washington Fort Washington Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 2 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖸 F 59 Yrs. 577-64-9586 1947 Washington, Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "naturel; or iteme 23s or 28s-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County the Medical Examiner must be notified at 1 Yes 2 □ No Directo DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20010 USA 1477 Newton St. NW apt. 202 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Private 7th permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any Injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Agnes Ponger Harry Tolson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8720 Cumbria Court Fort Washington, MD 20744 Agnes Colbert / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Aug.3,2006 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityJohnson and Jenkins Funeral Home 21. Signature of Funeral Service Licenses 716 Kennedy St. NW Washington, DC 20011 Approximate Interval Between Onset and Ceuth Part 1- Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Due to (or as Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a co Examiner physicien and s the burial-transit Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Records, P.O. Box 68760, Physician/Medical attending ( use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ 1 Tyes 2 No 3 Probably 4-√DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 2 No 1 Yes 2 🔀 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 12 Inpatient 3 DOA 2 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation м 1 Yes 2 No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide To the Hospitel within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -2006 P 30. Name and address of person who completed cause of death (Item And Type, Print) 11711 Livingston Rd. Fort Washington, MD 20744-5164 A. Mirza Alikhani, MD . Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 2 2006 Registrar

Dendel Andrew Bernard

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 28, 2006 2340 hrs Deue'l **Medical Examiner** Bernard Andrew 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Landover Northbound I-495 at Arena Drive 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10/22/1989 Foreign Trinidad
Country) 088-94-4296 Hours Min Months Davs 16 Director 1XXM 2 Usual Residence of Decedent 10d Inside City Limits IOc. City. Town or Location 10a. State 10b County 'n District Heights 1 X Yes 2 No MD Prince Georges 28a-f show notified at once. rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 1954 Rochelle Avenue #624 20747 USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S. White etc Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Black Yes .10 Yes 2 X No specify. If Yes, Give Year Widowed Divorced ours after is marked other than "natural", atic event, the Medical Examiner 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed N/A Elementary/Secondary (0-12) 10th College (1-4 or 5+) ges 1 and 2 should be filed within 72 l to f Health and Mental Hygiene If item 27 is marked other than "... Student Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Desmand Andrew Bernard Carol Moses Be Mailing Address \_ (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 1954 Rochelle Avenue #624 District Heights, MD 20747 Carol Bernard Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition Clinton, MD crematory or other place) artment of a portant: If other 1 XBurial 2 Cremation 3 Removal from State 08/05/2006 Ressurection Cenetery Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 814 Upshur St NW Wash, DC 20011 Bianchi Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED AMENDED ourial item#1,perME,g860, 10/20/06 TI Box 68760 23d Date of delivery tending physuse as the bi IF FEMALE 23b Was decedent pregnant in the Year Live buth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify, Yes 2 No 9 Unknown Q Unknown ned by the detached for 23e. Did tobacco use contribute to the cause of death? signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 2 1 Yes 2 No 3 Probably 4 Unknown Completed s been si should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has director, page 2 sl performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Be Other<sub>4</sub> DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 2 2 1 🗸 Yes 28a. Date of Injury Jul 28, 2006 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Passenger auto auto collision Certification: 2338 hrs Natural Yes 2 V No 5 Pending Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc filled in by 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town State Outerloop N/B 495 @ Arena Dr., Landover, Md (Specify) Interstate/Express the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifie July 29, 2006 O.C.M.E. Drassell

Registrar

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD 31. Date filed (Month, Day, Year) State

Assistant Medical Examiner

Registrar's Signature ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 28, 200<sup>°</sup>6° **Physician** 4:15 A. M Rosie Tolliver Butler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Largo HCR Manor Care 8. Date of Birth (Month, Day, 3/25/29 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7 Age (In vrs. last birthday) **Funeral** Min. Year) Days Months Hours 77 1 □ M 2√2 F Maryland Yrs. 578-36-8406 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic avant, Ite Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Washington D.C. Director 10g. Citizen of What Country? 10e. Street and Number 20019 5554 B St., S.E. U.S.A. Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc.
African-72 hours after 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Ano Specify: Baltimore, Maryland 21215-0036 ð 3 □Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Navy Annex d 2 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n U.S. Government Elementary/Secondary (0-12) Coltege (1-4or 5+) Computer Librarian 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Reuben Tolliver Mamie Smith ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Manor House Dr., Upper Marlboro, Md. 20774 19a. Informant's Name/Relationship (Type, Print, Pages 1 and 2 s ment of Health an ant: If Item 27 is Lester L. Butler, Sr. / Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò permit. Page Depertment of Importent: If any Injury or ance. 8/3/06 Suitland, Md. Lincoln Mem. Cem. 4 □ Donation 5 □ Other (Specify) <sup>2</sup>H<sup>N</sup>S°. Washingfolf & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee rau Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Infected Sacral Decubitus Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit Anemia that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Bacteremia use as the ned by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed 2□ No 1 ☐ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending after death.

I Director: Af
d in by the fue filled in by To the Hospital within 24 hours a

> State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date liled (Month, Day, Year) AUG 0 2 2006

29b. Signature and title of certifie

29a. Certifier

(Check only one)



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Dey, Year)

August 1,2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2006 July 29, 10:30aM Sakineh Bahramy 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital 8600 old Georgetown Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number Birthplace (State or Foreign Country) 1 □ M 2 😾 F 87 Yrs. 214-06-4929 January 10,1919 Iran Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits tx⊟xYes 2 No Maryland Montgomery Chevy Chase 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4701 Willard Ave. #1222 20815 IRan 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ∐Yes 2Ã No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Iranian Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Owner Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fazlolah Bahramy Esmat Eskandari 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bahman Sadr (Son) 8104 Whitter BLVD. Bethesda, MD. 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park8-01-2006 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility National Funeral Home 7482 Lee Highway Falls Church, VA. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death metastati Due to (or as a consequence of). Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 plonths? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XINatural 2 ☐ Accident Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Examiner burial-transit the attending physicien thed for use as the buria P.O. detached Vital Records, Hospital or Attending Physician:

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death.

after death

**Physician** 

/Medical

**Examiner** 

Director

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Completed

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Mudical Examinar must be notified at

permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygiene, important: If item 27 is marked other than "n sny injury or other treumatic event, The Media once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

Examine by Physician/Medical Completed Be 2 Certification:

Medical

To the Hospital within 24 hours at To the Funersi D

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Division of

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature a Name and address of person who

U

31. Date filed (Month, Day, Year) State AUG 0 2 2006 Registrar

3 🗌 Suicide

and manner stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23a) (Type, Print) Old Georgetown Rd. Betherda

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 Pending

investigation

6 Could not be determined

			For State	State of Man		artment of H			ene g. No 00	6 2	5835
- Fe	S. Carles	-	Registrar  1. Decedent's Name (First, Middle, Last	)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Death	)		me of Death
	Physicia /Medic	- 61	JOHNNY J	BEST				JULY 2	Day Ye	2 :	30. P M
	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of E	Death	
33		<u></u>	PRINCE GEORGE'S			CHEVERLY If Under 1 Year	If Under 24 Hrs.	C. Date of Birth		GEORG	
	Funeral Director		5. Social Security Number 6. Se 238–90–3454	X 7. Age (I. ZM 2□F	n yrs. last birthday) 56 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, DECEMBE	R 26. N	Country)	tate or Foreign AROLINA
	ס		Usual Residence of Decedent	^				DECLIBE			
	anylan show	5	Maryland Prince Geo		Dc. City, Town or La	cation Land	lover .				ide City Limits Yes 2 ☐ No
	the Mi	Director	10e. Street and Number	-8-		10f. Zip Code		10	g. Citizen of Wha		
	3a or		3971 Warner Aven	ne Apt. #D-6		101. 2.15 0040	20784		U.S.A.	,	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or iteme 23s or 28s-f show aumatic event, the Mudical Evantian must be notified at	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indi White, etc.	an,
Maryland 21215-0036	urs aft	þ	1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:		1□Yes 2ŽNo	Specify:		Specify:	Black	
5-0	72 ho Instur	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupa	luring most of works	ng 1	6b. Kind of Busin	ess/industry	
2	within ane. then	ig II	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired, Stock Clerk			Giant Food	1 Stores	
9	filed Hygie other	ပိ	12th grade  17. Father's Name (First, Middle, Last)		I		18. Mother's Name	(First, Middle, N	faiden Sumame)		
au	hental rked o	To Be	J	idhn Best			Mar	yme Knight			
ary	2 should and Men is marke		19a. Informant's Name/Relationship (7			ng Address (Street a		_			
	and and m 27		Mrs. Mary L. Best (WI		39/1 \ 20b. Place of Dispo	Warner Aven			Maryland Oc. Location - Cit		210
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other traumatic once.		20a. Method of Disposition  ↑☆Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Bethel Cer	matory or other place	a)	-	ethel, Nor		
Balt	permit. Page Department Important: If eny Injury o		21. Signa are of Funeral Service Licens	Inderen		2. Name and Addres	10		ral HOme, D.C. 200		
			23a. P. nt. Enter the lisease, or compose k, or heart failure. List only	olications that caused the one cause on each line.							eximate al Between t and Death
	Physician		Immediate Cause (Final disease or condition	, ME	tasta	tic C	olon	Can	cer-	Onset	and Death
	_/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):						
<b>6</b>	Be Burn	ē	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————	onsequence of):						
	outed Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
ő,	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a c	onsequence of):						
8760,	cate b physic the b	dica	•	d							
Box 6	death certifica attending ph I for use as t	an/Me	230. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of	,	Year
P.O. B	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□ Unknown		Other (specify)			Month	Day	real
	ss that gned b	by P	Part II. Other significant conditions of	· ·	not resulting in the u	nderlying cause give	en in Part I.		acco use contribu		
ord	w require been si should l	ted	_ coaquité	pachy				1 🗆 Ye	s 20 No 3	Probably	4 Unknown
Division of Vital Records,	: The law or cate has by page 2 sh	Completed by	$\bigcup$					24a. Was ar autops perforn	ned2 prio	r to completio th?	
tal		0	25. Was case referred to medical				26. Place of Deatl			Yes 2⊠N	0
<u>&gt;</u>	Physiclan: rthis certific ral director,	To B	examiner?	Hospital: Inpatient	2 ER/Outpatie	nt 3 DOA Oth	ar.		nce 6 Other	(Specify)	
0 _	ng Ph fter th ineral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Worl	κ?	28d. Describe ho	w injury occurred		
Sio	Attending in death.  ctor: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be		At home farm st		Yes 2 □No	28f Location /Str	reet and Number	or Bural Boute	a Number
Di≤	after Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	ioot, factory, office		City or Town	, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C		ysician: To the best of earner: On the basis of earner and manner state	kamination and/or in						ause(s)
	To the Within To the	Me	29b. Signature and title of certifier  ASPSE 5.	forine	MI)	29c. Licens	o 362		7.25		
2	_(2)		30. Name and address of person who	/					1.		
//	6 2 2 2	ate	31. Date filed (Month, Day, Year)	3 Registrar'	s Signature		1770	20	(20		
	Regist		JUL 3 1 200	16 Stown	1 Gr	who					

		-	For State Registrar	State of Maryland /		rtment of Hetificate of L			ene 0	06	25836
	Physici	_	1. Decedent's Name (First, Middle, Last)	BALLEY				2. Date of Death Month	Day	Year 2006	3. Time of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give str PRINCE GEDRG		AL	4b. City, Town, or CHEV	ERLY		4c. Count PRIM	y of Death	CENCES
6.	Funeral Director		370 32 1201	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Jan 24,	1926	_ Coun	lace (State or Foreign try). ginia
	Maryland f show	to.	Usual Residence of Decedent  10a. State 10b. County  Aryland Prince Ge	10c. City, To	own or Lo	cation Bowie	1			1	0d. Inside City Limits
	3a or 28a	Funeral Director	10e. Street and Number 1603 Whistling Du	ack Drive		10f. Zip Code 207	74	109	g. Citizen of U	What Coun	try?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Experimental by notified at	þ	11. Marital Status  1 Never Married 2 Married  3 November 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes _ 2점 No If Yes, Give Year or Dates:		Was Decedent of Hi I Yes, specify Cubar I ☐ Yes 2 No		ecify Yes or No- Rican, etc.)		ce - Americ ack, White, fy: B1	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's Educa (Specify only highest grade		(Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired, HOmemaker	luring most of world	ting 10	6b. Kind of E	Business/Ind	dustry
land 2	should be filed ind Mental Hygi s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Fadely Paige	'			Me	e (First, Middle, Ma lvina Jac	ckson		
	1 and 2 shou Health and A em 27 is ma other trauma		19a. Informant's Name/Relationship ( <i>Typ</i> Iris Christine Bail	ey-Grimes	1603	Whistlin	g Duck D	rive, U.	M⇒, M	D 207	74
Baltimore,	Page nent c ant: if ary or		20a. Method of Disposition 1 ☑8urial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Maryl	and :	sition (Name of natory or other place National	8/1/	2006	Oc. Location	1, MD	
Ball	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licensee		6	906 Kent'	Town Dri	ve, Lando	over,		ices, P.A. 785
8760,	Physician /Medical Examiner	lical Examiner	shock, or heart failure List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequent Due to (or as a conse	GE ce of):	WIC S	inoex Fran	WKE		1	Interval Between Onset and Death I Y HOUS I HOUS MOITH
O. Box 6	death certiff e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de 4□Pregnant at time of death 9□Unknown	ath 3	Ectopic pregnancy  Other (specify)				ate of delive	ery Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cont	nbuting to death but not resultin	ng in the u	nderlying cause give	en in Part I.	23e. Did toba	S		ne cause of death? pably 4 Dunknown
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of	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Ratural 5 Pending investigation		VOutpatier Bb. Time o Injury	Worl	er: 4 ☐ Nursing H	th (Check only one ome 5 Resider 28d. Describe how	nce 6 🗆 O	-	59)
Division	P Sign	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)				28f. Location (Str. City or Town,	State)		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	(Check only 2 Medical Examin one)	cien: To the best of my knowle er: On the basis of examination and manner stated.	n and/or in	vestigation, in my o	pinion, death occu	rred at the time, da	te and place	a, and due to	Othe cause(s)
	viti con	×	29b. Signature and title of certifler	Cach, MD		Doo	5148	5   EN GAT	7/27	120	06
R	- U		30, Name and address of ferson who con	npleted cause of feath (Item 23 I 13 E/JT - 4 C (	CLA	80 BO	WIE,	EN GAT	715	ANE	
	St Regist	ate rar	JUI 3 1 2006	Eleve &	200	W.					

			For State	State of Maryland				lental Hy	giene2 ()	06	25837
			Registrar		Cei	tificate of Dea	ath		Reg. No.		10.T(D)
	Physicia	an	Decedent's Name (First, Middle, La	•				2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	Salbrina Arle			th City Town and acco	tion of Dooth	July 2	2, 2006	of Dooth	6:18 p M
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	S. S.		5. Social Security Number 6. S		ast birthday)	If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birt	h	9. Birthp	place (State or Foreign
	Funeral Director			□M 201F 44	Yrs.	Months Days Ho	ours Min.	(Month, Da 08-26-	y, Year) 1961	Cour	ntry) ginia
			Usual Residence of Decedent								
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	and and and and and and and and and and	cto	D.C.		Wash	ington					1X Yes 2 No
	or 21	Director	10e. Street and Number	_		10f. Zip Code	•		10g. Citizen of	What Cour	itry?
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	er de	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No	5. 13.1	Was Decedent of Hispan f Yes, specify Cuban, Me	exican, Puerto	Rican, etc.)	Bla	ce - Americ ck, White,	
5	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:		i□Yes 2XINo Sp	ecity:		Specif	y: Bla	ck
Ş	stura		15. Decedent's E	ducation	16a. Dece	ient's Usual Occupation			16b. Kind of B	usiness/fn	dustry
15	within 72 ene. then "ne!	piet	(Specify only highest gri Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done during OO NOT use retired)	most of work	ing	The days of	II 1 4	1. Com.
212	d with	Completed	Elementary/Secondary (0-12)	2	Nu	rse			Unity 1	неатс	n Care
פ	be filed within 72 hours after death with the Marylan tal Hygliene. d other than "natural", or Items 23a or 28a-f show svent, Ite Maclical Examinat must be notified at	Bec	17. Father's Name (First, Middle, Last	)		18. !	Mother's Name	e (First, Middle,	Maiden Sumar	ne)	
<u>la</u>	should be find the high marked of imatic sveries	To E	Lewis Bell				Venus .	Jones			
Maryland 21215-0036	should and Men s marks sumatic		19a. Informant's Name/Relationship (		19b. Mailir	13th Street	lumber or Bura	al Route Numbe	er, City or Town	State, Zip	Code)
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ore	of Ho		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	sition (Name of natory or other place)		Date	20c. Location		
Ĕ	Pages ment of lant: if it		4 □ Donation 5 □ Other (Speci		-	emorial Pk.					•
Baltimore,	permit. Page Department of Importent: If sny Injury or once.		21. Signature of Funeral Service Lice	Bacon CC36	1 1 21	Name and Address of 47 14th Str					•
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ă	death e atte d for	Physician/Me	in the past 12 months?	1□Live birth 2□Fetal 4□Pregnant at time of de		Ectopic pregnancy Other (specify)			Me	onth	Day Year
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Ž	equir en si ould	bed le						10	Yes 2□No	3 Prob	pably 4 Onknown
Records,	law r as be	Completed						24a. Was autor	osv	Were auto	ppsy findings available impletion of cause of
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Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Certification:	4 Homicide determined		me, tarm, str	eet, factory, office		City or To		oer or Hura	al Route Number,
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	To t	Σ	29b. Signature and title of certifier	Make		29c. License nun			29d. Date signe		
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-(	3)		30. Name and address of person who	1 2500 2			205 -	01-	01		1-
	Service Av	10	31. Date filed (Month, Day, Year)	82. Registrar's Signal	huro		rine		my.	141	mylowa
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1		40.1	- 2000	Lucian De	1						

DHMH 17 Rev 1/2001

ORIGINAL

Daniel Joseph Bailev

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

- a	R	- For State	•	Certific	cate of t		· Wichte		g No 2(	006 258	3
Physician/ Medical Examine	1	Decedent's Name (First, Midd						2. Date of Death	Day Year	3. Time of Death 1345 hrs	
e dicai Examine		Daniel  4a Facility Name (if not institution	Joseph Bon, give street and no	ailey, Jr.	45	. City, Town, or L	ocation of	July 19, 20 Death	4c. County o		-
	ı	Prince George's Trau	ma Center			Cheverly			Prince G		
Funeral Director	1	5. Social Security Number	6. Sex	7. Age (In yrs last b	irthday)	If Under 1 Year Months Days		Min	,	Birthplace (State or Foreign	
Director		578-08-3688 Usual Residence of Decedent	1 X M 2 F	26	Yrs.			01/02	1/1980	cowarsh., DC	4
any	-	10a. State 10b. County		10c. City, Tow	n or Location	ı				10d Inside City Limit	
ž	5	DC					Was	hington		1 XYes 2 N	0
the Maryland a or 28a-f sh uified at once Director	2 F	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha	at Country?	
with the Maryland ns 23a or 28a-f show be notified at once. aral Director		155 Joliet	St., SW	#201 cedent Ever in U.S.	13 Was	Decedent of Hisr	2003	2 ? ( Specify Yes or No-	Unite	ed States - American Indian, Black,	4
er death with , or items 23	i i	1 XNever Married 2 N						uerto Rican, etc.)	White		
after or ral", or liner n			vorced If Yes, Give Ye	ar	-	es 2 No			Specify:	Black	_
11215-0036 Id be filed within 72 hours after fental Hygiene narked other than "natural" event, the Medical Examine or Brown or Br	g	15. Decedent's Education (Spe Elementary/Secondary (0-12)		1-4 or 5+)		Usual Occupation of working life.			16b. Kind of Bus	siness/Industry	
D36 thin 72 ne r than ledical		12th		,		Car	Broke	r	Se <sup>-</sup>	lf-Employed	
5-0 lied w Hygie I other		17. Father's Name (First, Middle				1	18.Mother's	Name (First, Middle, M	faiden Surname)		
ould be filed within 7 ould be filed within 7 ould be filed within 7 ould be simarked other than its event, the Medica To Be Comple	8	Danie1 19a. Informant's Name/Relation		ailey, Sr.	19b. Mailing	Address (Street	t and Numb	Sandr er or Rural Route Num	a D. Sm	ith n. State. Zip Code)	4
		Daniel J. Bai		1.4	_	,				o. MD 20774	1
re, l s I and f Healt If item er trau		20a. Method of Disposition  1 XBurial 2 Crematio			e of Disposit atory or othe		netery,	Date	20c. Location -	City or Town, State	
imo Pages ment o tant: I	1	4 Donation 5 Other S	Specify.		rrect	lon Ceme	terv	7/25/2006	Clir	nton, MD	
Baltimore, MD permit. Pages I and 2 sho Departion of Health and Department: If them 27 is injury or other traumat	- 1	21. Signature of Funeral Service	< 1	A TIT		me and Address	-	Stewart F			
<sup>5</sup> Physician	77	23a. Part Enter the disease, o	r complications that	caused the death. Do	not enter the	mode of dying,	nning such as car	diac or respiratory arre	wash est, shock, or hea	Approximate Interva	
/Medical Examiner	74	failure. List only one cause Immediate Cause (Final disease		ounds (2) of hea	ıd					Between Onset and Death	3
.xammer		or condition resulting in death)		a consequence of):							
<u> </u>	اةِ	Sequentially list conditions, if any, leading to immediate		a consequence of):							
led Insit	틟	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	a consequence of):							_
executed an and al - transit		events resulting in death, cast	d	<u> </u>							
	Medical	UNPENDED	AMENDED								
8760, ifficate being physicials the burian	- 10	IF FEMALE: 23b. Was decedent pregnant in	the	, outcome of pregnand birth		Il death 3	Ectopic p	pregnancy	23d Date of Month	delivery Day Year	
Box 687 is death certifing the attending ted for use as the attending the attending ted for use as the attending the attending the attending ted for use as the attending the attending ted for use as the attending ted for use at the attending ted fo	sician	past 12 months?  1 Yes 2 No 9 Ur	okoowo I	nant at time of death	_	er (Specify)					Į
· - > - 1	≥١	Part II. Other significant cond	9 Unk	nown to death but not result	ting in the ur	derlying cause g	iven in Part	1. 23e. Did to	bacco use contri	bute to the cause of death?	_
P.C res that signed be deter	à							1 Yes	2 No 3	Probably 4 V Unknown	ı
rds, requires been should	ete							24a. Was autop		Vere autopsy findings availab rior to completion of cause of	
Reco	Completed							perfor		leath?  Yes 2 No	
Division of Vital Records, P.O pital or Attending Physician: The law requires that to ours after death.  Filled in by the funeral director, page 2 should be detached in the funeral director. To De Committed by the forest of the forest of the forest of the forest or the forest of th	Be	25. Was case referred to medic examiner?	Hospital.				Other -	Check only one)		7	_
of Vir	유	1 Yes 2 No 27. Manner of Death	28a Dat	Inpatient 2 ER	/Outpatient b. Time of In	o Don	ry at Work?		Residence 6	Other:	_
On on on on on on on on on on on on on on	Certification:	1 Natural 5 Per	nding FOUN	th Day, Year) FO	OUND: 215 hrs		res 2 🗸 N	Subject sho			
IVISION or Attendather death Director:	<u> </u>			ace of Injury - At home		, factory, office b	uilding, etc.	28f. Location (S		er or Rural Route Number, Cit	у
Di Spital nours a filled	5	4 Momicide	1	/) Home				3685 Jay St	reet Northea	st, Washington, DC	_
	Medical							e, and due to the caus urred at the time, date			
To the within To the comple	Med	29b. Signature and title of certif	and manner	stated		29c. License	e number		29d. Date signe	ed (Month, Day, Year)	
		Thed	11 Km	of The	w	Ø 0.C.I	M.E.		July 20, 20	06	
2	ŀ	30. Name and address of person				144 De Ct	rest Dell	imara MD 0400			
N U		Theodore M. King, J 31. Date filed (Month, Day, Year		tant Medical Exa	uniner	Penn Str	eet, Balt	imore, MD 21201	· · · · · · · · · · · · · · · · · · ·		
Sta Registra		JUL 2 8	·	wer &	Could	را					
DHMH 17 Rev 1/200	01				RIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician July 29, 2006 Ingrid Brown 12:45A<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Silver Spring 11003 Ascott View Lane 5 Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 1 - 31 - 60 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2€ F 46 Yrs. Director 579-84-6336 Wash. DC Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits orient: it tiem 27 is marked other then "naturel", or liems 23a or 28e-f show injury or other treumatic event, the Medical Examiner must be notified at e. 10a State 10b. County MD. Montgomery Silver Spring XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 11003 Ascott View Lane U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Never Married 2 Married Specify: Black 1 Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within Department of Health and Mental Hygiering Importent: If Item 27 is marked other then any injury <u>of other</u> treumeth Elementary/Secondary (0-12) College (1-4or 5+) Account Payable Clerk Unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gloria Williams Emmitt Brown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnesha Day/Daughter 11003 Ascott View Lane, S.S. Md. 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/5/06 Washington, D.C. Rock Creek Cemetery 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature Funeral Service Licensee W. Hackes 814 Upshur Street, N.W. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure. Heart Congestive Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician by Physician/Medical as the esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ö Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown á peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? pe 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ₹ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No completely filled in by the 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD DOOS 7627 0

Registrar

State

Reginald

31. Date filed (Month, Day, Year)

AUG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2131

street N.W. site 800 Wash. DC 20037

30. Name and address of person who completed cause of death (fem 23a) (Type, Print)

2006

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32 Registrar's Signature

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02

			For State Registrar	Stat	e of Ma	ryland			t of Hea e of De		Mental Hy	giene Reg. No.2	006	25840
			1. Decedent's Name (First, Midd	le, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic		Frances	"Faye"	В	rodv					8/1/06			6:15 A M
,	Examin	-	4a. Facility Name (If not institution					4b. City,	Town, or Loc	ation of Death	1	4c. Cou	nty of Death	
			Manor Care Po	tomac					omac				tgomer	~
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗹		(In yrs. las		If Under Months		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birth	place (State or Foreign intry)
	Director		123-01-1170	10.00 202		88	Yrs.				9/11/1	917		NY
	and *	1	Usual Residence of Decedent  10a. State 10b. Count	1		10c. City,	Town or Lo	ocation					T	10d. Inside City Limits
	Aaryl f eho	ō				_								1X∑Yes 2 ☐ No
	288-	Funeral Director	MD Mont	gomery_		Poto	mac	10f. Zip	Code			10g. Citizen	of What Cou	intry?
	With Be or	0	10/12 Crossin	crook	Pond				20854			IIni.	ted St	ates
	ne 2	era	10412 Crossin	12. Was	Decedent E	ver in U.S.	. 13.	Was Deced	ent of Hispan	nic Origin? (S	pecify Yes or No	- 14. F	Race - Ameri	ican Indian,
0	r fter	Fur	1 Never Married 2 Ma	rned 1 🔲	ed Forces? Yes 2 ⊡XN	io		_	_	lexican, Puert	o Hican, etc.)		Black, White,	, etc. White
8	af, o	by	3 ☐ Widowed 4 ☐ Divorce	1 17 7 6	s, Give 22 r or Dates:			1 ☐ Yes	SXT NO 2	pecity:		Spe	ciry:	
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or freme 23e or 28e-f ehow the Maryleal Exeminar marst be notified at	Completed	15. Decede (Specify only high	nt's Education	eted)		(Give	kind of wo	al Occupation	n ng most of wor	rking	16b. Kind of	Business/Ir	ndustry
2	ithin	du	Elementary/Secondary (0-12)		ege (1-4or 5-	+)	life.	DO NOT us	se retired)					
2	led w lygier her ti	S	12	( and )			Chil	d Car	e Work		ne (First, Middle			munity Cent
and a	be fi	Be	17. Father's Name (First, Middle	, Last)								, Maidell Sun	amo,	
<u> </u>	d Mer d Mer nark	5	Jacob Koch	ahin (Time Drin	.el		10b Maili	na Addross		ora Sa	LIIII ural Route Numb	er City or Tox	un State Zi	in Code)
<u>a</u>	12 st h and 7 ts n traun		19a. Informant's Name/Relation Dr. Michael B					-			load Pot			
ტ _	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiane. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-f show eny Injury or other traumatic event, the Madical Examinar must be notified at once.	1 3	20a. Method of Disposition	Louy L	, on	20b. Pla	ce of Dispo	sition (Nar	ne of	J. C.C.	Date		on - City or T	
Baltimore, Maryland	S T T S		1 N Burial 2 ☐ Cremation		from State	Cer	metery, cre	matory or o	therplace) metery	, ¦ 8	3/2/06	Elmon	t NY	
	rtant		4 Donation 5 Other (						d Address of					
Ва	Depa Impo eny I		21. Signature of T		-		Da	nzans	ky-Gol	ldberg	Memoria			
			23a. Part1. Enter the disease,	or complications	that caused	the death.	Do not en	70 Ro	ckvill le of dying, si	Le Pike uch as cardiad	Rockvi or respiratory a	11e MD	20852	Approximate
		3 (	shock, or heart failure. List Immediate Cause (Final	t only one cause										Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Seps		ance of):							
	Examiner						Dist	ensio	n					
		ē	Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury	b. Di	ue to (or as a									
	d d ansit	Ē	Cause (Disease or injury that initiated events	1	Non-	Hodgk	ins L	ympho	ma					
Ć,	exec en an rial-tr	Examiner	resulting in death) Last	D.	ue to (or as a	a conseque	ence of):							
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$\widetilde{\mathbf{o}}$	leath certifica ettending ph i for use as th	Med	IF FEMALE:									1	1	
Вох	death certific e ettending p id for use as	an/l	23b. Was decedent pregnant in the past 12 months?		s, outcome		death 3[	⊒Ectopic p				23d.	Date of delin	very Day Year
	0 0 0	sici	1 ☐ Yes 2 ☐No 9 ☐ Unknown		Pregnant at Unknown	time of dea	ath 5[	Other (sp	pecify)					,
0	that the ed by th detache	Physician/Med	Part II. Other significant condi	tione contribution	a to death h	at not cocul	ting in the	undorking o	auso auson is	n Part I	23e Did	tohacco use o	ontribute to	the cause of death?
	8	ğ	Part II. Other significant condi	IOHS COMMUNICATI	g to death of	at not resur	ung in the t	andenying c	ause giveir ii	iraiti.		Yes 2□N		
Records,	red noul	Completed												Λ
ec	law as b	d d									24a. Was		b. Were aut prior to c death?	topsy findings available ompletion of cause of
<u> </u>	page et	Š									1 □ Yes		1 Yes	2 XNo
Vital	ysicfan: Th is certificete director, pag	Be	25. Was case referred to medic examiner?	Hospital:					Other		ath Check only			
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ב	iding Phy th. After thi funeral	on O	27. Manner of Death 1 ∑Natural 5 □ Pend	ling	Date of Injur (Month, Da)	Year)	Injury	M	28c. Injury at Work?	2 🗆 No	280. Describe	now injury oc	Curred	
<u>s</u>	Attending r death. ector: After by the fune	icat	3 Suicide 6 Coul		Place of Inju	ury - At hor	ne farm st				28f. Location	(Street and Ni	umber or Ru	ral Route Number,
Division	or A after Direction by	ertification:	4 Homicide deter	mined 200.	building, etc			reot, ractor	y, onice			wn. State)		
_	Hospital 24 hours ( Funeral tely filled	O	29a. Certifier 1 Certify	ing Physician:	To the best of	of my know	vledge, dea	th occurred	at the time,	date and place	e, and due to the	cause(s) and	I manner as	stated.
	To the Hospital or Atten within 24 hours efter deat To the Funeral Director: completely filled in by the	edical		al Examiner: On		examinati								
	To the within 2 To the comple	Me	29b. Signature and title of certif	j <b>è</b> r	10	iA	10		c. License nu			29d. Date si		
			> Kurt	ゴレ	oh	9 M	1.0)	D	-2027	4		August	1, 20	006
	7		30. Name and address of person	n who complete	d cause of d	eath (Item	23а) (Туре	, Print)			,J.			
			DR. Kirti Voh						da MD	20817				
		ate	31. Date filed (Month, Day, Yea		3. Registra									
	Regist	rar	AUG 02	2006	BOOK-	15	15000	The same of the sa						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** JUL 27 2006 AMANDA SUE BALMER 11:10 A<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year)
July 24,2006 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 4 Hours Min. None 1 ☐ M 2 🖾 F Yrs Bethesda, MD Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show MD Gaithersburg 1 XYes 2 No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 United States 18868 Bent Willow Circle #1115 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "naturel", or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or item eny injury or other traumatic event, the Mudical Example once. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Susan Miller Russell Balmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18868 Bent Willow Circle#1115, Gaithersburg, MD 20874 Russell Balmer/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Marial 2 Cremation 3 Removal from State Arlington Nat Cem 8-3-06 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANENCEPHALY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learning transport cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 💢 No 1 Yes or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D-58202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 MICHELLE B. KRAVITZ 31. Date filed (Month, Day, Year) Registrar's Signature State 02 2006 AUG Registrar

			For State Registrar	State of Ma	aryland /		ment of H		ind M		iene	200	6 2584	2
			1. Decedent's Name (First, Middle	, Last)						2. Date of Deat _Month		Year	3. Time of Death	
	Physici /Medic		INEZ	B. BAILE	ΞY					July 2	25 Pay	200 6	11:05PM	
	Examin		4a. Facility Name (If not institution,	-			. City, Town, or					County of Dea		
			Summit Park					tons				BALTI		_
	Funeral		,	6. Sex 7. Age	(In yrs. last		Under 1 Year onths Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Feb. 2	Year)	9. Bir	thplace (State or Foreign Duntry) Maryland	
L	Director		214-38-4056		93	115.				reb. 2	.o, 1	913	Maryland	_
	and wa		10a. State 10b. County		10c. City, To	own or Location	on						10d. Inside City Limits	_
	danyl f ehc	ō	MD Bal	timore		Ca	atonsv	ille					1 X Yes 2 No	
	the 1	rect	10e. Street and Number				Of. Zip Code			1	0g. Citiz	en of What Co	ountry?	-
	3a or	□	3 Cargil A	vemue			21	228				U.S.A		
	me 2	by Funeral Director	11. Marital Status	12. Was Decedent 6	Ever in U.S.	13. Was			gin? (Spe	crfy Yes or No- Rican, etc.)		4. Race - Ame	ncan Indian,	-
٥	or ite	교	1 Never Married 2 Marri	Armed Forces? ed 1 ☐ Yes 2 🔀 N	10				, Puerto F	Rican, etc.)		Black, Whit		
2	2 hours after death with the Maryland atural; or iteme 23a or 28a-f ehow isal Examiner must be notified at		<b>X</b> Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Yes 2√2 No	Specify:			3	Specify: Bl	ack	
9500-91212	72 h	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16	6a. Decedent' (Give kind	's Usual Occupa I of work done of NOT use retired	ation during most	of workir	ng	16b. Kin	d of Business	/Industry	
7	within 72 ene. than "na! he Medic	дш	Elementary/Secondary (0-12)	College (1-4or 5	+)							Dand	L _	
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ב	be fi	Be	17. Father's Name (First, Middle, I Henry Lyle							e Thon		ournaine)		
چ	nark natic	၉	19a. Informant's Name/Relationsh		1	Ob Mailing A	ddraes /Straet s			Route Number		Tour State	Zin Code)	
Maryland	ss 1 and 2 should of Health and Me item 27 is mark r other traumation		Lorraine Baro							Scotch				5
	1 and Health sm 27 sther tr		20a. Method of Disposition	tay (Niece			n (Name of ory or other place					ation - City or		
٥	Pages nent of I		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sg				ry or other place Cemete		Ω/1	106	R=1	timor	MD	
Baltimore,	mit. Pages partment of portant: If it or or or or or or or or or or or or or		21. Ignature Juneral Service		71000								OME, P.A.	-
g	Dep Imp eny		1 8MG X	Mour	leu 1								,MD 20850	
			23a. Part1. Enter the disease, or	complications that caused	the death. D								Approximate	Ī
	Pnysician		shock, or heart failure. List of Immediate Cause (Final	only one cause on each in	ration	n b		MILA					Interval Between Onset and Death	
-	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	ce of):	newn	7 7000					1 us	-
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	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	De to (or as	a consequent	ce of):							1	
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2 68 X	death certificat e ettending phy id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of programmy									
Box	ettend ettend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal dea	ath 3 □Ect	opic pregnancy her (specify)				23	3d. Date of de Month	livery Day Year	
o.	at the de by the e	yslc	1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregnant at 9 Unknown	time of death	1 3 U	ner (s <i>pecity)</i>							
مز	res that I	4	Part II. Other significant condition	ns contributing to death be	ut not resulting	g in the under	lying cause give	en in Part I.		23e. Did to	Dacco us	e contribute to	the cause of death?	Ī
Records,	iaw requires that es been signed b 2 should be deta	d by								1 □ Y	s 2	<b>(</b> √10 3 □ P	robably 4 Unknown	
ဂွ	w require been signature	lete								24a. Was a	n	24b. Were a	utopsy findings available	-
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Vita	ifficet or, p	0	25. Was case referred to medical					26 Place	of Death	(Check only on	2000	1 🗆 Yes	2 No	_
	nysicien: nis certific director,	To B	examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/	Outpatient 3	B DOA Othe	25 6		ne 5 Reside		□Other (Spe	icifv)	
o	- = a		27. Manner of Death	28a. Date of Injur		b. Time of Injury	28c. Injury Work			8d. Describe ho				-
ō	ath. r: After	atlo	1 Natural 5 Pending	ation	, , , ,			Yes 2□N	No					
Division		Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, c. (Specify)	, farm, street,	factory, office		2	8f. Location (Si City or Town		Number or R	ural Route Number,	_
	rs aft		100											
	Hospital or At 124 hours after Ge Funarel Directetely filled in by	cal	(Check only 2 Medical I	g Physician: To the best of Examiner: On the basis of	examination									
	To the Hospital or within 24 hours after To the Funarel Dirt completely filled in I	Medical	29b. Signature and title of centrier	and manner sta	1180.		29c. License	number		2	9d. Date	signed (Mon	th. Dav. Year)	_
)	± ₹ 8			MM.	Ohic		7 ,	7 97	60		-	7/3//0		
	12		30. Name and address of person	who completed cause of d	eath (Item 23.	a) (Type, Prin	it) .	- 1 /	- 1	Λ.		11/1	0	-
			Marcelino	D Allera	reno	MO	516 N	Rol	11/11	9 Rd	Ba	Ut- N	12 2 1228	
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	Registi	ar	AUG 0	2 2006	the st.	19	-							

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			Hygien	21101	25843
	Physici	an	Decedent's Name (First, Middle,	Last)				2. Date of Month	Da	ay Year	3. Time of Death
	/Medic		Betty Jane Bo			1 0 -		Augu		3 2001	
	Examin	er	4a. Facility Name (If not institution,			4b. City, Town,			40	c. County of Dea	
	Funeral		Washington Co	. Sex 7. Ag	Cal je (In yrs. last birthda)	) If Under 1 Yea		24 Hrs. 8. Date of	of Birth	9. Bir	ington thplace (State or Foreign
Н	Funeral Director		218-24-1228	1□M 2 <b>X</b> F	77 Yrs.	Months Days	s Hours		18 19		aryland
	put &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
	Maryla feho	ō		ington		erstown					1 Yes 2 No
	28a-	rec	10e. Street and Number		1149	10f. Zip Code			10g. C	itizen of What C	ountry?
	th witi	Funeral Director	212 Rock Willo	w Avenue			21740			U.S	.A.
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of If Yes, specify Cu	Hispanic Or ban, Mexical	igin? (Specify Yes on, Puerto Rican, etc	or No-	14. Race - Ame Black, Whi	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married  3 ☑ Wildowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 □ Yes 2 📉	o Specify:			Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or items 23e or 28e-f ehow is Manical Exercities mail be notified at	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occ e kind of work don	upation	A of working	16b. l	Kind of Business	/Industry
215	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use retir	red)	at of working		-	
	led w tygier her th		9 17. Father's Name (First, Middle, La	nat)		Homemaker		er's Name (First, Mi			Residence
Maryland	d be find the cod of	Be c	Alvey Beachle	•			15. 100011	Bessie Ke	_		
ary.	shoul nd Me mark	၉	19a. Informant's Name/Relationship	-	19b. Mai	ling Address (Stree	et and Numb	er or Rural Route N			Zip Code)
	and 2 salth a n 27 is		Danny Lee Gar	ling II (gr			Willow	v Avenue H			ryland 21740
Baltimore,	Jes 1 of He If item or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State		ematory or other p		Date		ocation - City or	
텵	t. Pag rtment rtant:		4 Donation 5 Other (Spe			o Cemete		Aug 7 200	1		o Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or Items 23s or 28s-f show any jury or other traumatic event, its Medical Examinal must be notified at one.		21. Signature of Funeral Service Li	V. XIM			stern	Blvd.		ery Fun gersto	eral Home wn Maryland
n			23a. Part1. Enter the disease, of constant shock, or heart failure. List or	ny one cause on each i	ine.	nter the mode of d	ying, such as	cardiac or respirate	ory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	α.		Scous					2 DHS
н	Examiner				a consequence of):	TA CTATIC	DUM	wind Can	nllen		6 months
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_ 0 0 830	alli Uni	VUIL		UTICHES
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. RENAU							
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687	physicate sthe			d							
Box (	w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□5-tasia				23d. Date of de	livery
9	deatl	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		☐Ectopic pregnar ☐ Other (specify)		***	-	Month	Day Year
P.O.	The law requires that the site has been signed by the bage 2 should be detache	Phy	9 Unknown		out not requiting in the	underhing course	muna ia Dart I	220	Did tobacco	uca contributo t	o the cause of death?
	signer d be d		Part II. Dther significant condition	s contributing to death t	out not resulting in the	underlying cause (	jiven in Part i			use contribute t	1
Ö	v requ been shoulk	etec							Was an		utopsy findings available
Rě	4 S CA	Completed							autopsy performed?	prior to death?	completion of cause of
ta		0	25. Was case referred to medical				26. Place	e of Death (Check of	es 2 N	o 1 ☐ Ye	s 2□ No
<b>&gt;</b>		To B	examiner? 1 ☐ Yes 2 Ø No	Hospital:	ent 2 ER/Outpati	ent 3□ DOA	ther: 4 🗆 Nu	ursing Home 5	Residence	6 □Other (Spe	ocify)
Division of Vital Records,	ing Pl		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury	W			ribe how inju	ary occurred	
Sio	death death stor: /	cat	2 Accident investiga 3 Suicide 6 Could no	t be age Place of In	jury - At home, farm, s		∏Yes 2∏		ion (Street a	nd Number or G	ural Route Number.
<u>≥</u>	s after st Direct od in by	Certification:	4 Homicide determin	ed building, e	ic. (Specify)	areat, factory, office	•		r Town, Stai		urai rigate rianiper,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying 2 Medical E	Physicien: To the best kaminer: On the basis of and manner st	of examination and/or	ath occurred at the investigation, in my	time, date ar opinion, dea	nd place, and due to ath occurred at the t	the cause(sime, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	Vithii To th	Me	29b. Signature and title of certifier			1	nse number		1	ate signed (Mon	
•			1 Eleds	V/			4656	)	1	UG. 03	,2006
3	H-10			RADIR 1	190 MT A		OAD	1-1AGBR	370 W	N MO	21740
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 7	2006 32. Regist	rar's Signature	1					
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ORIGINAL

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25845 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Dorothy Catherine Banagan August 11, 2006 1:25 A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 38835 Van Ward Road Abe11 St.Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Days 1 ☐ M 2 🗓 F 213-38-3830 69 February 28,1937 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Maryland St. Mary's Abel1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38835 Van Ward Road 20606 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify Specify 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Corporate Officer Janitorial Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Herman Gass Myra Marguerite Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Marshall Banagan/ Husband 38835 Van Ward Road , Abell, Maryland 20606 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) 15. 2006 Sacred Heart Cemetery Bushwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, Maryland 20650 Ichael 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC CANCER OUMMINN disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Minth, Day, Year) 29b. Signatu and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road, Hollywood, Maryland 20636 David M. Federle, M.D. 31. Date filed (Month, Day, Year)

State Registrar

filled in by the funeral

After

Director:

within 24 hours after To the Funerel Dire To the Hospital

death.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

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in then "natural", or Iteme 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, since.

**Physician** 

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Division of Vital Records, P.O. Box 68760,

Examine

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Certification:

Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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			For State		State of	r Maryland		artment of F rtificate of	lealth and I Death	vientai Hy	- ()	006	258	3 45
			1. Decedent's Name	First, Middle, L	ast)			tineate of	Douis	2. Date of De			3. Time of	f Death
-	Physicia		James	Arthur	Butler	•				July	Day	2006	6:4	5 AM
	/Medic Examin	11	4a. Facility Name (I						or Location of Deatl		4c. C	County of Death		
	HE.		Genesis						aston			Talbo		
	Funeral Director		5. Social Security N 219-36-	-6527	Sex 1MM 2□F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 6 - 8 -	1940	9. Birth Cou Ea	place (State on Intry) Ston,	Md.
	land ow		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ocation					10d. Inside C	
	a-fsh	ctor	Md	Talbot		st.	Mic	naels					1 📑 Yes	2 🗆 No
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel", or Items 23e or 28e-f show event, I're Medical Evaniral must be neithed at	ai Director	10e. Street and Nur 211 Dods		P.O.	Box 52	25	10f. Zip Code 2166	3		10g. Citiz	en of What Cou USA		
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tler 21215-0036	2 hour			15. Decedent's E	ducation	ales.	16a. Dece	dent's Usual Occup	pation		16b. Kin	d of Business/Ir	ndustry	
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Baltir	permit. Pag Department Importent: I eny Injury o		21. Signature of Fu	ineral Service Lice	ensee	1	R	Cemete Name and Addre Carro	ess of Facility 11 Hurle	ey Fune	eral	Home,	PC	
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9.	Physicien: The law requires that the death certificate r this certificate has been signed by the attending physral director, page 2 should be detached for use as the	/ Ph	Part II. Dther signi		contributing to de	eath but not resu	ulting in the u	inderlying cause gr	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of	death?
rds	quires n sigr uld be	ed by		Doly	fee ,					1 🗆	Yes 2□	No 3∏Pro	bably 4 🗹	Unknown
000	law requir as been si 2 should I	plete	7	norw	d alle	sily				24a. Was		24b. Were aut	opsy findings	available
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on	Attending r death. ector: After by the fune	tion	1 ☑ Natural 2 ☐ Accident	5 Pending investigati		of Injury th, Day Year)	Injury	Wo	ork? ]Yes 2 □No		. , ,			
Division of Vital Records, P.O. Box 68	l or Atter after dea Director	Certification;	3 Suicide 4 Homicide	6 Could not determine	be 28e. Place buildi	of Injury - At ho ing, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location City or To	(Street and own, State)	Number or Rui	ral Route Nun	nber,
D	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier						ime, date and place					
	the Ho hin 24 h the Fui	edical	(Check only one)	2 Medical Ex		pasis of examina iner stated.	tion and/or ir		opinion, death occi	urred at the time				5)
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	ž.			KIL			226) (7	Print	,,,,		1-1	31-06		
~~	3-		30. Name and add	SANC	HEZ MI	$\Delta$ 5	08	LDUEW	ILD AV	ENUE	E	9STCN	MD.	2160
	Sta Regist	ate rar	31. Date filed (Mor		2006	egistrar's Signa						,		

Record   Part				For State Registrar	State of Ma	aryland /	Depa <i>Cer</i>	rtmen tificat	t of H e of L	ealth a	ınd M	ental Hy	giene 2	06	251	34
Sarch Anselma Burgett   Scillar Street	Die	. volei		1. Decedent's Name (First, Middle, Last,	)									Year	3. Time of I	Death
Boundard   Control   Con			_	Sarah Anselma Bur	gett							07/25	/2006		4:56	PM
South Service Number   Gas   South Service   Gas   South Service   South Ser								•						•		
Social Part   Social Part						- // / /-	1.46 ( )					0 D-1(D)		-	<u> </u>	
To a State   10c. Courny   10c. Dry, Town or Location   10c. Process   10c. Courny   1				556-12-9076 <sup>1D</sup>			* .					(Month, D	1921	Cou	ntry)	roreign
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	/land	펵	-			10c. City, To	wn or Lo	cation							10d. Inside City	y Limits
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	Man	fled	ţ	Maryland Prince Ge	orges	Bowie									1 XYes	2 🗌 No
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	th the	pue	lrec					10f. Zip	Code				10g. Citizen of	What Cou	ntry?	
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	th wi	1		3112 Teton Lane				207	15				USA			
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	r des	1	nue		Armed Forces?		13. V	Vas Deced Yes, spec	dent of Hi	spanic Orig n, Mexican,	in? (Spe , Puerto l	cify Yes or Na Rican, etc.)	0- 14. Fla			
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	s afte	art.	드		If Yes, Give	10	1	I □ Yes	<b>2√</b> No	Specify:			Speci			
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	hour	E E	ed t			16.	a Decec	lent's Usua	ai Occupa	ntion			16b Kind of F			
17, Father's Name (First, Middle, Mascer Jumme)   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   18, Mother's Name (First, Middle, Mascer Jumme)   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Agnes Doran   19, Mairy Adness Greet and Minister of Part Agnes Doran   19, Mairy Ag	in 72	Specific	plet	(Specify only highest grad	le completed)		(Give	kind of wo	rk done d	lurina most	of working	ng	Tob. Kind of t	20011000	140311)	
David Michael Species    Table   David Michael Species	nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 is marked other then "naturel", or	17	E		College (1-4or 5		ome l	Maker					Own Ho	me		
David Michael Species    Table   David Michael Species	e filec	Vent,								18. Mother	r's Name	(First, Middle	, Maiden Suma	me)		
20. Membed of Deposition   Date   20. Location - City or Town, State   20. Location - City or City or Town, State   20. Location - City or	uld b Menta	tic	2	David Michael Spen	ce					Mary	Agn	es Dor	an			
20. Membed of Deposition   Date   20. Location - City or Town, State   20. Location - City or City or Town, State   20. Location - City or	snd l	mne		19a. Informant's Name/Relationship (Ty	rpe, Print)	19	b. Mailin	g Address	(Street a	and Number	r or Rura	Route Numb	er, City or Town	, State, Zip	Code)	
1.   Agental 2   Diseased   Tomaria   Tomari	and and	ier tr	-		t II/ Son	_				Road						
23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest, immediate cause (First Desivered Cheer of Death Cheer of Dea	of H	i o			Removal from State	20b. Place cemet	of Dispo ery, cren	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Location	- City or To	own, State	
23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of drying, such as cardiac or respiratory arrest, immediate cause (First Desivered Cheer of Death Cheer of Dea	Pag	ury				Resur										
Sequentially list conditions cause on each line.  Respiratory Failure  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Chronic Obstructive Pulmonary Disease  Due	permit. Pages 1 at Department of Heal Important: If item	eny in		21. Signature of Funeral Service Licens	<u> </u>										1 Home	
9 Unknown  9 Unknown  9 Unknown  9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Congestive Heart Failure  1	/Med Exam	dical iner parial-transit	cai	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as b. Chronic Due to (or as c.	obstruca consequence	e of): Ctiv e of):		mona	ry Di	seas.	e			Onset and D	eath
Congestive Heart Failure    Congestive Heart Failure   Congestive Heart Fai		ached for use as t	hysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deal									•	ear
Suicide   Suic	uires tha	o eq p	þ			ut not resulting	in the ur	nderlying c	ause give	n in Part I.						
Suicide   Suic	The law requires to the has been signer	362	omplete	Cor Pulmonale					-·			auto	psy orroad?	prior to co death?	mpletion of ca	
Suicide   Suic	sician: T	tor. p						Sec		26. Place	of Death			10 165	2 140	
Suicide   Suic	Physical raths co	ੂਰ			Hospital: 1 ∭∏npatie	nt 2 ER/C	Outpatien	t 3 DC	Othe	r: 4□Nur	rsing Hom	ne 5∐Res	idence 6 □Ot	her (Specit	(v)	
29a. Certifier (Check only one)  29b. Signature and didless of person who completed cause of death (Item 23a) (Type, Print)  Neeraj Aropra, MD PO Box 83819 Gaithersburg, MD 20883	ing Afte	n in in		1 X Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	ry Year) 28b.				at	2				,	
29a. Certifier (Check only one)  29b. Signature and didless of person who completed cause of death (Item 23a) (Type, Print)  Neeraj Aropra, MD PO Box 83819 Gaithersburg, MD 20883	F 0 F	d in by th	ertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju- building, etc	ury - At home, c. (Specify)	farm, stre	et, factory	, office		2			ber or Rura	al Route Numb	er,
30. Name and address of person with completed cause of death (Item 23a) (Type, Print)  Neeraj Aropra, MD PO Box 83819 Gaithersburg, MD 20883	Mospite 24 hours	letely filler		(Check only 2   Medical Exami	ner: On the basis of	examination a	ge, death and/or inv	occurred restigation	at the tim	e, date and inion, deat	d place, a h occurre	nd due to the	cause(s) and m date and place	anner as s	tated. the cause(s)	
30. Name and address of person with completed cause of death (Item 23a) (Type, Print)  Neeraj Aropra, MD PO Box 83819 Gaithersburg, MD 20883	To th within	dwo	Me	29b. Signature and title certified									29d. Date signe	ed (Month,	Day, Year)	
30. Name and address of person with completed cause of death (Item 23a) (Type, Print)  Neeraj Aropra, MD PO Box 83819 Gaithersburg, MD 20883	,- > -			M\\() N	Oa			1	054	347			07-20	5-20	06	
			ł	30. Name and address of person who co	ompleted cause of d	eath (Item 23a	) (Type,	Print)		7						
State 31. Date filed (Month, Pay, Year) 2006 Registrar's Signifiure				Neeraj Aropra, MD			aith	ersbu	rg,	MD 20	883					
		Sta	te	31. Date filed (Month, Pay, Year) 201	Registra	ar's Signature	La	and a		,						

BURGETT, SARAH

06-05485		pe or Print in Black Indelible Ink			
Dorothy Lanell Bede	ell Carter State of Maryland /	Department of Health and Mental F	lygiene		
	1- For State Registrar	Certificate of Death	Reg No.	2006	2584
Physician/	Decedent's Name (First, Middle,Last)		2. Date of Death		ime of Death
Medical Examiner	Dorothy LaNell Car	ter Bedell	Month Day July 27, 2006	Year 1	1722 hrs
The state of the s	4a Facility Name (if not institution, give street and number)	4b City Town, or Location of Deat	h 4c. Co	ounty of Death	

		1- For State Registrar		Certific	cate of	Death		F	Reg No.	UU6 2584
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd		Carter Bed	lel1			2. Date of De Month July 27, 2	Day Yea	3 Time of Death 1722 hrs
		4a. Facility Name (If not institution 635 Elk Mills Road	n, give street and r	umber)	4	b. City, Town, or Elkton	Location of D	eath	4c. County Cecil	of Death
Funeral Director		5. Social Security Number 551-51-8460	6. Sex	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	<del></del>	Min	5, 1964	9 Birthplace (State or Foreign California Country)
Aaryland 28a-f show any <u>1 at once.</u>	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Cec	i1	10c. City, Tow		on				10d Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 635 Elk Mills	Road			10f. Zip Code 21921			10g. Citizen of Wi	hat Country? ed States
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she marte event, the Medical Examiner must be notified at once	by Funeral		arried Armed I 1 Yes orced If Yes, Give Ye or Dates:	2 X No	If Ye	Decedent of His s, specify Cuban  Yes 2 X No s Usual Occupat	Mexican, Pu		0- 14. Race White Specify:	e-American Indian, Black, e, etc.  White usiness/Industry
5-0036 Jed within 72 hou Hygiene other than "nat	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	during mo	st of working life. ress/Bar	tender	retired)	Resta	urant
1215-0 be filed vantal Hyginred other	a	17. Father's Name (First, Middle Thomas Carter					Billi	lame (First, Middle, e D. Ril	еу	
MD 21  od 2 should dith and Me m 27 is ma aumatic er	2	19a. Informant's Name/Relations Michael A. Har		./Son	P.O.	Box 221	, E1k	Mills, Ma	aryland 2	
MOFA, Pages I an tent of Hee mut. If itel r other tr		20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other S	pecify:	from State crem	atory or oth F <b>erris</b>	& Co., In	c. 2	Ju1y 29, 2006	West Penns	- City or Town, State Chester, ylvania
Balti Permit Departu Importa		21. St. nature of Funeral Service 23a. Part I. Enter the disease, or	8 Hill	caused the death. Do	High 10.	ame and Address KS Home W. Sto e mode of dying,	for Facility for F ckton such as cardi	unerals, Street, I	P.A. Elkton, M rrest, shock, or he	Maryland 21921 art Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a Narcot	ic intoxicati a consequence of):	on					Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.st	a consequence of):						
ecuted and - transit		events resulting in death) Last	d	a consequence of):						
8760, Tificate be executed ng physician and as the burial - transit	Medic	X UNPENDED  IF FEMALE.		item#23a,27		perÆ,g85	8,8/19/0	06 TT // i	tem#1,perM	
68 certif nding se as	Physician/Medical	23b. Was decedent pregnant in t past 12 months?  1  Yes 2 No 9 ✓ Un	4 Preg	birth gnant at time of death nown		al death 3 [ er (Specify)	Ectopic pro	egnancy	Month	Day Year
b, P.O. E	ğ	Part II. Other significant condi	tions contributing	to death but not result	ing in the u	nderlying cause g	iven in Part I.	23e. Did		ibute to the cause of death?  Probably 4  Unknown
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternompletely filled in by the funeral director, page 2 should be detached for u	Completed								opsy formed?	Were autopsy findings available prior to completion of cause of death?  Yes 2 No
al Fian:	Be C	25. Was case referred to medica examiner?						neck only one)		
Vit Physic This c	To E	1 ✓ Yes 2 No	Hospital: 1		/Outpatient	0 00/1		ursing Home 5	Residence 6	
1 of Jing Ph After t funeral		27. Manner of Death  1 Natural 5 Pen		th, Day, Year)	o. Time of Ir		ry at Work? ∕es 2 <mark>v</mark> No		how injury occur	
Sior Attend death death sector:	cati		Sugation	7/27/2006 F ace of Injury - At home	nd 5:18	) µII	Λ	Subject	ingested	drugs er or Rural Route Number, City
Divis spital or At tours after dueral Directified in by	Certification	4 Homicide dete	ermined (Specif	y) found	at hor	ne		or Town, Elkton,	State) 635 E	1k Mi11s Road
To the Hos within 24 h To the Fun	ical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	aminer: On the basi	est of my knowledge, o s of examination and/o	death occurr r investigati	ed at the time, da on, in my opinion	ate and place, , death occur	and due to the cau red at the time, date	use(s) and manner e and place, and c	r as started due to the cause(s)
To To COUT	Medical	29b. Signature and title of certifi	and manner	stated		29c. Licens				ed (Month, Day, Year)
		Pottuber 0130 Name and address of person	on-P	allali -	1	O.C.I	M.E.		July 28, 20	006
		Patricia Aronica-Polla		itant Medical Exa		111 Penn St	reet, Baltir	more, MD 212	01	
Ragis	tate	31. Date filed (Month, Day, Year,		Registrar's Signature	Avai	Sis.		- '		

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar		partment of Health and ertificate of Death	Mental Hygier	2000	2584					
	Physici	an	Decedent's Name (First, Middle, Last)     MARY SUNDAY BUR	METT		2. Date of Death Month AUG • 6 , 2	Pax Year	3. Time of Death					
2	/Medic Examir		4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Dear		4c. County of Death	7:35A M					
	. Sar	П	SOUTHERN MD.HOS		CLINTON  If Under 1 Year   ff Under 24 Hrs		RINCE GE						
	Funeral Director		5. Social Security Number 6. Sex 578-26-3744	7. Age (In yrs. last birthda M 2 F 83 Yrs.	Months Days Hours Min		9. Birthol Coun 922 NEW	lace (State or Foreign try) JERSEY					
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			0d. Inside City Limits					
	a-f ehc	tor	MD. PRINCE G	EORGES CLIN	TON			1X Yes 2 No					
	23a or 28	al Director	10e. Street and Number 8600 MIKE SHAP	RIO DRIVE	10f. Zip Code 20735		Citizen of What Coun	try?					
36	urs after dea	by Funeral	11. Maritaf Status 12 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 3 ☐ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	etc.					
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after deats with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f ehow other treumatic event, it is Medical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  HOMEMAKER  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HOMEMAKER  OWN HOME										
2	illed v I Hygie other I	Be Co	6th 17. Father's Name (First, Middle, Last)			me (First, Middle, Maid							
ylar	ould be Menta Merked Merked	To B	LUGIO DIORIO			ANCE CARME							
Mar	od 2 sh ith and 27 is m treum		19a. Informant's Name/Relationship (Type PASTOR CLIFFOR		iling Address (Street and Number or $R$ ) $10712$ WACO DR.								
Jore,	Pages 1 ar hent of Hea int: If itam. iry or other		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Re	20b. Place of Dis	position (Name of rematory or other place)	Date 20c.	Location - City or Tov	wn, State					
Baltimore,	permit. Pages 1 and 2. Department of Health at Important: If item 27 is eny injury or other tretonce.		4 □ Donation 5 □ Other (Specify)  21. Signature of 5 Oheral Service Licenses	1100	22. A YMOND FUNERA	L SERVICE	, P. A.	, •					
	ELE E G		23a. Part1. Enter the disease, or complication	ations that caused the death. Do not e	LA PLATA, MARYL	AND 20646		Approximate					
1	Physician /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	0	1 mon 19			fnterval Between Onset and Death					
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyping Cause (Disease or injury	Due to (or se a nonesquanea of):									
8760,	cate be executed hysicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):									
Box 687	eath certificate ettending phy for use as the	n/Medic	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy			23d. Date of deliver	у					
P.O. B	res that the deat signed by the ettr be detached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□ Ectopic pregnancy □ Other (specify)		Month (	Day Year					
ords, F	The law requires that the death certific tie has been signed by the etlending p bage 2 should be detached for use as	Ď	Part II. Other significant conditions contr	ibuting to death but not resulting in the	underlying cause given in Part I.		use contribute to the						
		Completed	HC	1 peranson		24a. Was an autopsy performed? 1 Yes 250 N	death?	sy findings available ipletion of cause of					
	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	spital: 1	0.00	ath (Check only one)	6 DOther (Specific)						
Division of	ding Ph n. After <sup>§</sup> h funeral		27. Manner of D th 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how in							
		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural ite)	Route Number,					
	To the Hospital or within 24 hours effe to the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 ertifying Physic 2 Medical Examine	cian: To the best of my knowledge, deal:  On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occur	e, and due to the cause( arred at the time, date a	s) and manner as sta nd place, and due to t	ted. the cause(s)					
	within 2 To the Complet	Σ	29b. Signature and title of certifier	. /	29c. License number	29d. D	ate signed (Month, D	ay, Year)					
7		1	30. Name and address of person who com	pfeted cause of death (Item 23a) (Tvni	D 46478	8-	, , , ,	-					
٠,	H		Syreth late	(MD 7501 84		ntonm	D 2073	35					
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 6 2006	32 Registrar's Signature	anti I								

			1 - For State Registrar		State of Ma	•	_	artment of F			Re	g. No. 2	006	2585
	Physici	an	1. Decedent's Name (First, I	Middle, Las W	CURTI	- C				M	ite of Death onth UST 1.	Day	Year	3. Time of Death  1:40 A M
	/Medic Examir	al	4a. Facility Name (If not insti					4b. City, Town, o	r Location of Dea		wi 1,	1	unty of Death	1:40 A
	Exami	lei	SOUTHERN MARY	LAND	HOSPITAL			CLINTON				PRI	NCE GE	ORGES
	Funeral Director		5. Social Security Number 579–22–1284		71M 2 T E	e (In yrs. last birth	rs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n /M	te of Birth onth, Day, [ 5, 1	<sup>Year)</sup> .925	9. Birth Cou NOR	place (State or Foreign ntry) TH CAROLIN
	nyland show	_	Usual Residence of Decede  10a. State 10b. Co			10c. City, Town	or Lo	cation				<u> </u>		10d. Inside City Limits
	Ba-f e	Director		ICE GI	EORGES	CAMP	SP					1 XYes 2[		
	death with the Maryland me 23a or 28a-f ehow r nuat be notified at	al Dir	10e. Street and Number 5509 LANSING	G DRIV	<b>/</b> E			10f. Zip Code 2074	43			10g. Citizen of What Country? UNITED STATES		
0000	n 72 hours after death with the Marylan "naturel", or Items 23s or 28s-1 ehow edical Examiner inval be notified at	by Funeral	11. Marital Status 1 1 Never Married 2 3 Widowed 4 Divo		12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:1	do l		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 No		(Specify Y erto Rican,	Specific			
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and	id be lental ked o	To B	CLAUDE CURT	IS					MARTHA	CURT	[S			
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Ξ,	and 2 ealth a n 27 i		SHERRI LATTIS	SAW/N	IECE				LAKE PL		-			, MD 20743
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	Physician /Medical Examiner	L	Immediate Cause (Final disease or condition resulting in death)	ſ	a. Due to (or as	ARDIAL a consequence of	·):	INFAC	tion			1		Interval Between Onset and Death
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coras, r	law requires that the as been signed by th 2 should be detache	ρ	Part II. Other significant co	nditions co	ontributing to death bu	ut not resulting in	the ur	nderlying cause giv	ren in Part I.	2:		cco use c		he cause of death?
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Ē	sician; Th certificete rector, pag	ပိ	25. Was case referred to me	edical					26. Place of De			No	1 🗌 Yes	2□ No
>	Physician; r this certific ral director.	ToB	examiner? 1 ☐ Yes 2 🕱 Ŵo		Hospital:	nt 2 ER/Outp	atien	t_3 DOA Oth					Other (Specia	(v)
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	tal or Attendir s after death. el Director; Af ed in by the fur	Certification;		ould not be etermined	28e. Place of Inju- building, etc	ury - At home, farr c. <i>(Specify)</i>	n, stre	eet, factory, office			cation (Stre ty or Town,		umber or Run	al Route Number,
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edicai	29a. Certifier 1 Certifier (Check only one)	tifying Phy dical Exam	ysician: To the best of iner: On the basis of and manner sta	examination and	death or inv	occurred at the tir restigation, in my o	me, date and place opinion, death occ	ce, and du curred at t	e to the cau he time, dat	ise(s) and e and plac	manner as s ce, and due t	stated. the cause(s)
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5	Rich		30. Name and address of pe	rson who d	completed cause of de	eath (Item 23a) (T	ype,	Print)	on Road	Fin	, F 1. JA	Stin	cta a	my back
4	DD : Sta	te	31. Date filed (Month, Day,	Year)	32. Registra	ar's Signature	(	Livinger	AM . CONF				Y	1 4124
	Registi	ar	AU	G 0 2	2006	eve &	4	park						
υH	IMH 17 Rev 1/2	100												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 2006 Year **Physician** 30, July 3:30 a M MARIA ESTHER CATAN de PADILLA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hyattsville Sacred Heart Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 26, 1911 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛱 F Yrs. 120-66-5587 94 Argentina Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or then "neturel", or items 23s or the Medical Exeminer must be a 20817 7625 Edenwood Court Argentina Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1⊠Yes 2□No Specify: Argentinian Baltimore, Maryland 21215-0036 Specify. þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 7 is marked othe treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Manuel Catan Ermelinda Vallejo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Elisa Freeman - Daughter 7625 Edenwood Court, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If ony injury or once. Gate Of Heaven Cemetery | 8/2/06 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Ponstance aseh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Congestive Heart Failure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Progressive Cognitive Decline 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 10 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 √ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L Medical 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D005112 7/31/2006 Esmerando O. Juanitez, M.D. 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) 1160 Varnum Street, N.E., Suite #008, Washington, D.C. 20017 31. Date filed (Month, Day, Year) 32 Registrar's Signature \_\_ State Registrar

06-05826

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Paris Craig 1- For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle,Last) Date of Death 3. Time of Death Physician/ 0909 hrs **Medical Examiner** Paris August 6, 2006 Craig 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 1c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours 577-41-8236 Directo September 16,2005untr/Wash.,D.C  $_2$ X 1 M 10 Usual Residence of Deceden ú 10a. State 10b. County I0c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No or 28a-f show fied at once. Md. Montgomery Silver Spring after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 2120 Harlequin Terrace 20904 U.S.A. items 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funera 12: Was Decedent Ever in U.S. 14. Race - American Indian, Black White, etc African-Armed Forces? 1 X Never Married 2 Married 2 X No Yes American f Yes, Give Year Yes 2X No specify Widowed Divorced Specify 'natural", ģ 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within 72 hours of Health and Mental Hygiene

If item 27 is marked other than "natur ther traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+ None timore, MD 21215-0036 None 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gaskins Kim Craig Be Darryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Craig/Mother 2120 Harlequin Terr, Silver Spring, Md. 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State permit Pages
Department of
Important: 1 Chesapeake Crematory, Inc. 8/11/06 Beltsville, Md. Other Specify Donation 5 or 22. Name and Address of Facility
H. S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019
Approximate Interval 21. Signature of Funeral Service Licensee au W als 23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Sudden unexplained death in infancy Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter U. denying Causa (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED physician item#23a.27.28a-f.perME.2859.9/19/06 TT Box 68760 IF FEMALE 23c. If yes, outcor 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of Hospital or Attending Physician: The law performed? death? this certificate ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 DOA 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work's Certification Natural 5 Pending 1 Yes 2 X No Fnd 8/6/2006 Fnd 8:35 am unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Location (Street and Number of Rural Route Number, City of Town, State) 2120 Harlequin Terrace Liver Spring, MD 3 6 X Could not be Suicide Silver determined found in residence Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the I 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License numbe 29d. Date signed (Month, Day, Year) O.C.M.E August 7, 2006 30. Name and address of person who completed cause of death (Item 23a Assistant Medical Examiner Carol Allan, MD 111 Penn Street, Baltimore, MD 21201

State Registra

31. Date filed (Month, Day, Year)

2006

AUG

Ricardo Nolasco - Cruz Please Type or Print in Black Indelible Ink 06-05699 State of Maryland / Department of Health and Mental Hygiene UNK UNK 1- For State Certificate of Death Registrar , Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Year 1908 hrs **Medical Examiner** August 2, 2006 Jose Ricardo Nolasco Cruz 4b. City, Town, or Location of Death c County of Death 4a Facility Name (if not institution, give street and number) Rock Creek Park, 12800 block Viers Mill Silver Spring Montgomery If Under 1 Year | If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) **Funeral** Months Days Hours 5cHonduras Director none July 20,196 41 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State Ob. County any Rockville Yes 2 X No MD Montgomery 28a-f show once. Director 10f. Zip Code 10g. Citizen of What Country' 10e Street and Number notified at Honduras 1015 Baltimore Road 20851 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 2. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Honduran White after Yes, Give Year 1 X Yes 2 No specify. Specify Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) be filed within 72 hours Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than " atic event, the Medical 21215-0036 Unemployed and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Balbino Nolasco Ercilia Cruz Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Jose Carlos Nolasco Baltimore, MD ruz 1015 Baltimore Rd. Rockville, Md. 20851 Important: If item 27 permit Pages 1 and 2 Department of Health 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition Santa Lucia, 2 Cremation 3 Removal from State Cemeterio de Santo 1 X Burial 8/16/06 Honduras ucia PHILIPADS RINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 9241 23a Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval Between Onset and Physician failure. List only one cause on each line. /Medical Death Drowning complicated by acute alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician/Medical XUNPENDED AMENDED attending physician item#23a,27,28a-f,perME,g858,8/19/06 TT Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE. 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 1 🗸 25. Was case referred to medica 26. Place of Death (Check only one) Be Other<sub>4</sub> examiner? Hospital: DOA Nursing Home 5 Residence 6 V Other Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 1 Yes 2 No Pending Fnd 8/2/2006 Fnd 7:00 pm subject drowned 2 Investigation 28f. Location (Street and Number or Rural Route Number. City or Jown, State) Rock Creek Park, 12800 blk Veirs Mill Road Silver Spring, MD 28e Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined (Specify) found in creek 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: within 24 hours after death fo the Funeral Director:

> Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 3, 2006

29c License number

O.C.M.E.

31 Date filed (Month AUG 1 2006

29b. Signature and title of certifier

and manner stated

State

Registra

			For State Registrar	State of Ma	aryland		rtment tificate			nd Mer		iene g. No. 2	006	258	354
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			Shady Grove Ad  5. Social Security Number 6. Sex		HOSE e (In yrs. la		If Under 1		kvil If Under 24		Date of Birth		ONTGON 9. Birth		r Foreian
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Baltimore, Maryland	permit. Pages 1 Department of H Important: If Ite any injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Cel	metery, cren	natory or oth	ier place)		8/2				oring,	MD
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of		.: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Inju	ry :	R/Outpatien 28b. Time of		c. Injury a	at □ Nurs		5 Reside			iry)	
io	Attending I r death. ector: After by the funer	atio	1. ■ Natural 5 Pending 2 Accident investigation	(Month, Da	y rear)	Injury	М	Work? 1 ☐ Ye	es 2 No	0					
Division	l or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At hor c. (Specify)	ne, farm, str	eet, factory,	office		28f	Location (St City or Town		lumber or Ru	ral Route Numi	ber,
0	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the			Notes With the total	AF clouded and	acrycia nascwa	PourTypean	1363-30		To Barrier To Brown	ELECTRON OF CO.	un elektron and	* 1814 - 1717 - 1717		
	To the Hospital within 24 hours a Volume a To the Funeral Completely filled	edical	(Check only one)	ner: On the basis of and manner sta	f examination										
	omple	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date s	igned (Month	, Day, Year)	
	2		1 Mm	m.	>			53 (	654	+		Jul	125	T, 200	,6
			30. Name and address of person who co	ompleted cause of d	leath (Item	23a) (Type,	Print)	7							
			31. Date filed (Month, Day, Year)	7701	Me	91/Cart	Ctyr	erv	Nive	1100	acu'll f	h	1) 20	820	
120	Sta Registi		The state of the s	006	KON A	1. P	254EL							(), Day, Year) (), 200	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10a-c, 10e, f, perINF., G869, 776707, WS

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar		State of N	naryland / Dep <i>Ce</i>	ertificate of		-	eg. No.	06 2	5856		
	Physici	an		ne (First, Middle, Las	st)				2. Date of Dea Month	Day	Year	ne of Death		
	/Medic	al	Roslyn				45 ON T		July	29, 20 4c. County		02 P.M		
7	Examin	er		(If not institution, give Home of G		n ashington	Rockvi	r Location of Death 11e			gomery			
	Funeral Director		5. Social Security I	Number 6. S		Age (In yrs. last birthday 87 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 30		9. Birthplace (St Country) New Yo	ate or Foreign rk		
	and w		Usual Residence of	of Decedent 10b. County		10c. City, Town or L	ocation				10d. Insid	de City Limits		
	Be-f aho	Director	Florida Maryland	Palm Beach	ry	West Palm I Rockville	Beach				¹ <del>X</del>	Yes 2□No		
	23e or 2	al Dire	10 <b>2593 Didl</b> 6121 Mont	ey Dr. W. Ap	pt C.		10f. Zip Code 3374	15 52		U. S				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. important: if item 27 ia marked other than "natural", or Items 23a or 28e-f ahow any injury or other traumatic event, the Modical Exercit or must be notified at once.	d by Funeral		rried 2☐ Married 4 ☐ Divorced	12. Was Deceder Armed Force; 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	ŽINo	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		pecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American India k, White, etc. White			
15-0	natu natu	Completed	(Spe	15. Decedent's Edecify only highest gra	lucation de completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work	king	16b. Kind of Bu	siness/Industry			
12	withir iene. than	omp	Elementary/Sec 12 Year	ondary (0-12)	College (1-4o	ir 5+)	Homemake			Own	n Home			
פֿ	e filed al Hyg other	BeC		(First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Surname	э)			
ylaı	2 should be f n and Mental h ia marked of raumatic eve	To	Jack Be					Sonia	Rossman					
Maryland	d 2 sho h and 7 ia m traum	1		Name/Relationship (7			ling Address (Street			-				
	Heelth tem 27	l X	20a. Method of Dis	H. Carlin	- Son	20b. Place of Disp	4 MacDuff  cosition (Name of ematory or other place	Avenue,			L 20832 City or Town, Star	te		
e E	Pages nent of int: If its			Cremation 3 🗓 5 ☐ Other (Specify			ark Cemet		-1006	Paramus,	New Je	rsey		
Baltimore,	permit. Departmit. importa any inju		21. Signature of F	uneral Service Licen	S00	Ď	22. Name and Addre Janzansky- 170 Rockv	ss of Facility Goldberg ille Pike	Memoria:	l Chapel ille, Ma	ls, Inc.	20852		
			23a. Part1. Enter shock, or he	the disease, or compart failure. List only	plications that caus one cause on each	ed the death. Do not en	nter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approx Interva	imate I Between		
	Physician			ion	aMET,	4STATIC	CAR	CINOMA	0 F L	LUNG	SOnset	and Death		
	/Medical Examiner		resulting in death)	mmediate Cause (Final isease or condition a sulting in death)  a. METASTATIC CARCINGMA OF LUN Due to (or as a consequence of):  b. Due to (or as a consequence of):										
	4	Jer	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of	onditions, mmediate	b. Due to or a	as a consequence of):	CINEMA	0,000	CLCR					
	cuted	Examiner	that initiated event	ts 🔳	С.									
50,	tificate be executed ig physician and as the burial-transit	Ē	resulting in death)	Last	Due to (or a	as a consequence of):								
68760,	physics the b	edicai			d									
P.O. Box (	The law requires that the death certificate be executed ethe has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was deceded in the past 12 1  Yes 2 9 Unknown	2 months?		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify) _	1		23d. Date Mon	of delivery th Day	Year		
	res that signed by be deta	by Ph	Part II. Other sign	ificant conditions o	ontributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use contri	bute to the cause	of death?		
rds	w require been sig should b	ed b	CHR	inic O	BS TRUL	TIVE PUL	MONARY	DISEA.	SE 1□Y	es 2√∏No	3 ☐ Probably 4	Unknown		
of Vital Records,	The law re ete has be page 2 sh	Completed			Latrica	a Jonest	eo May	med mine	24a. Was a autops perform	y p π <del>o</del> d? d	/ere autopsy findi rior to completion eath? ☐ Yes 2 No	ngs available of cause of		
Vita	ician: Th certificate rector, pag	Be	25. Was case refe examiner?	irred to medical	Hannital:		100	26. Place of Dear	th (Check only on	Ie)				
of	Physic rthis ral dir	- T	1 🖰 Yes 2 🗆 27. Manner of Dea		Hospital: 1 ☐ Inpa				ome 5 Reside					
lon	nding th. :: After s tuner	ation	1 ☐Natural 2 ☐ Accident	5 Pending investigation	(Month, E	Day Year) Injury	Wor	k? Yes 2 □ No		, , , , , , , , , , , , , , , , , , ,				
Division	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of I	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Si City or Town	treet and Numbern, State)	or or Rural Route	Number,		
	Hospite 24 hours Funeral etely fille	Medical C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the bearing: On the basis and manner	st of my knowledge, dea o examination and/or i stated.	ovestigation in my o	ninion death occur	red at the time d	ate and place a	nd due to the cau	se(s)		
	within To the	Me	29b. Signature and	d title of certifier			29c. Licens	e number	2	9d. Date signed	(Month, Day, Yea	ar)		
	10	1	<b>&gt;</b>	Twee	ciew,	Com	1)00	018084	A	rucus	101,2	006		
	1 4		30 Name and add	Iress of person who	Completed cause of	f death (Item 23a) (Type M-D- 012 (	29c. Licens  ) 06  , Print)  MONT/	LOSE RD,	Rock	ille M	02085	2		
	Sta Registr		31. Date filed (Mo.		32 Regis	strar's Signature	marke							

State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 🗎 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 12: 04 AM CUSTER August L. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye JUNE 29, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number , 1913 PENNSYLVANIA **Funeral** Days Months Yrs. 93 Director 181-03-5356 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ansit: if tiem 27 is marked other than "natural", or iteme 23e or 28e-f ehow ury or other treamatic event. Its Medical Exaction must be notilised at ury or other treamatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 XNo Funeral Director **BOONSBORO** MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21713 U.S.A. 8925 MAPLEVILLE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ WHITE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING MANUFACTURE SEAMSTRESS 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FLORENCE M. KLINE HOWARD H. LINSENBIGLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8925 MAPLEVILLE ROAD, BOONSBORO, MARYLAND CHRISTINE A. MARTZ/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State permit. Page Department Important: If any injury or 4 Donation 5 Other (Specify) SMITHSBURG CREMATORY 8/07/2006 SMITHSBURG, MARYLAND 7606 Old National Pike 21. Signature of Aunoral Savice 22. Name and Address of Facility BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a consequence of): Cardiovabeler diserse Examiner ertersu Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of): Examiner Due to the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown sete has been signed pege 2 should be de 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 ∑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 √ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred tnjury at Work? 1 X Naturat 5 Pending hours efter death. Inerel Director: Al 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) δ 4 🗌 Homicide To the Funeral Dir To the Hospital Medical 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) opal 31. Date filed (Month, 26 AUG 0 7 32. Registrar's Signature State 2006 Registrar

			State of Maryland / Do	ера		of H	ealth a		ental Hyg	giene	_	25858
			Registrar  1. Decedent's Name (First, Middle, Last)	761	liiiCale	OIL	Jeani	- 1	2. Date of Dea	Reg. No.	- W W	3. Time of Death
	Physicia	an							Month	Day		
	/Medic	al.	Verfinia Mae Clary  4a. Facility Name (If not institution, give street and number)		4h City	Fown or	Location of	f Death	August	5	2006 County of Dea	7:00 A <sup>M</sup>
	Examin	er	20 E Street				ke Pa				-	
	<b>.</b>		5. Social Security Number 6. Sex 7. Age (In yrs. last birth.	day)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birtl	h	arrett 9. Bir	thplace (State or Foreign
	Funeral Director		220-16-5751 1 M ZX F 80 Yr		Months	Days	Hours	Min.	(Month, Day Dec. 25	, Year)	, a	ountry)
	_		Usual Residence of Decedent							,	,	
	rylan	_	10a. State 10b. County 10c. City, Town	or Lo	cation							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f s	cto	MD Garrett Mtn.	La								21
	or 2	Director	10e. Street and Number		10f. Zip	Code				10g. Citi	zen of What C	ountry?
	ath w		20 E Street			2155		i=0 /0=			ed Sta	
	er de Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Deced If Yes, spec	ent of Hi rfy Cubai	spanic Orig n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 🔯 Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1□ Yes 2	ON	Specify:				Specify: W	hite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene.  d other than "netural", or Items 23e or 28e-f show do other than "netural", or Items 20e or 28e-f show event, Ite Madical Examiner must be notified at	ed		Dece	dent's Usua	I Occupa	ıtion			16b. Ki	nd of Business	
<u>د</u> ا	nin 72 n "ne Madili	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Give life.	dent's Usua kind of wor DO NOT us	k done d e retired,	luring most )	of worki	ng			
212	d with giene r tha	E O	12	H	omemal	ker					Own Ho	me
פ		Be C	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
<u>a</u>	should be nd Mental marked o matic eve	ToE	Taylor Male				Il	da N	orthcra	ft_		
ary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailir	ng Address	(Street a	n <i>d Numb</i> e	r or Rura	d Route Numbe	r, City o	r Town, State,	Zip Code)
	로 # 2 # E								Park,			
ore	es 1 a of Hea f item r othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Commetery,	Dispo , <i>crei</i>	sition (Nam natory or ot	ne of ther place	e)	[	ate	20c. Lo	cation - City or	Town, State
Ĕ	Pages nent of ent: If it ury or o		'4 □ Donation 5 □ Other (Specify) Garret	t l	Memor	ial (	Garde	ns 8	/8/06	0ak	land,	MD
Baltimore,	permit. Pages Department of I Importent: If it eny injury or o		21. Signature of Funeral Service Licensee	22	2. Name an	d Addres	s of Facility	y Bu	rdock-D	urst	Funer	al Home
<u> </u>	g Q ∓ ₽ 9		Katherine Sweizer			:	21 N.	Sec	ond St.	<b>,</b> 0a	kland,	MD 21550
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot ent	er the mode	e of dying	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
, P	Pnysician		Immediate Cause (Final disease or condition a. pneumonia									1 week
	/Medical- Examiner		resulting in death)  a. Pre-unit of Ta  Due to (or as a consequence of	f):								- week
li.	± t	<u></u>	Sequentially list conditions,  b. chronic obstr  Due to or as a construence of		tive	pu	lmon	ary	disea	se		yrs
	ted nsit	njne	Sequentially list conditions, it by list light to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			410	***	15	r dico	200		1
	and and al-tra	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of		. car	410	vasc	ита	r dise	ase		l_yr
760,	ate be executed hysician and he burial-transit	cal	d									
89	leath certificat attending phy I for use as the											
Box	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 [	]€ctopic pr	eanancy				2	23d. Date of de	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death		Other (sp						Month	Day Year
0	The law requires that the deaste has been signed by the a cage 2 should be detached to	hy	9 Unknown						A			
	es th igned	by	Part II. Other significant conditions contributing to death but not resulting in the	the u	nderlying ca	ause give	in in Part I.					o the cause of death?
ord	w require been signature should b	ted							Y	'es 2[		robably 4  Unknown
Records,	has by	Completed							24a. Was autop	SV	prior to	utopsy findings available completion of cause of
_		Con							perfor 1 ☐ Yes	med? 2 ANo	death?	s 2 No
Vital	ysician: The lis certificate hadirector, page	Be (	25. Was case referred to medical examiner?			_			(Check only o			
	Physician: r this certific ral director,	P	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	-					me 5 AResid			ecify)
n c	ding P	ion:	I MINAGE S I Briding	me o jury		8c. Injury Work	rat (? Yes 2.⊟1		28d. Describe h	iow injur	y occurred	
2	Attending ir death. ector: After by the fune.	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	n et	M factory	_	163 2		28f Location (S	treet an	d Number or F	ural Route Number,
Division of	or A after Direction by	Certification;	4 Homicide determined building, etc. (Specify)	11, 30	oot, raciory	, onice			City or Tow	n, State	)	arar riouje ryambori
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	deat	h occurred :	at the tim	ie, date and	d place,	and due to the	cause(s)	and manner a	s stated.
	24 h	edical	(Check only 2 Medical Exeminer: On the basis of examination and one) and manner stated.	or in	vestigation,	in my op	inion, deat	th occurr	ed at the time,	date and	place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	_			number				e signed (Mon	
	. 21.0		+ anald / / when the		7	D30	035			08–	05-200	)6
			30. Name and address of person who completed cause of death (Item 23a) (T					14				
_	3		Donald R. Richter, M.D. 1533	M	lemor	ial	Dri	ve	Oaklan	d,	MD 215	550
ž.	Sta		31. Date filed (Month, Day, Year)  AUG - 7 2006  32. Registrar's Signature		P							
	Registi	ar	700 - 2000	1	300/3	0						

			State of Maryland / Department of Health and N Certificate of Death	•	giene <sub>Reg. No.</sub> 2 () (	06 25859
	Physici		1. Decedent's Name (First, Middle, Last) William R. Crissey	2. Date of De Month JULY		3. Time of Death 7:15 pm
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  Goodwill Mennonite Home  4b. City, Town, or Lo			f Death
	Funeral Director		5. Social Security Number 16. Sex 155-24-7740 11 M 2 F 7. Age (In yrs. last birthday) 16 Yrs.  17 Age (In yrs. last birthday) 17 Age (In yrs. last birthday) 18 Months 19 Days 19 Hours 19 Min.	8. Date of Bir		Birthplace (State or Foreign Country)     PA
	nyland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	with the Maryland or 28a-f show	Director	PA Somerset Co. Salisbury  10e. Street and Number 10f. Zip Code		10g. Citizen of WI	1 Yes 2 No
	23a or	ral Dir	70 Grant St. 15558		USA	nat Country ?
020	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be mulfied at	by Funeral	If Yes, Give 1 ☐ Yes 2 ☑ No Specify:  3 ☐ Widowed 4 ☒ Divorced Year or Dates:	ecify Yes or No Rican, etc.)		- American Indian, , White, etc. White
Baltimore, Maryland 21215-0020	filed within 72 hours Hygiene. other than "natural", ent, the Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Laborer  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Laborer	16b. Kind of Bus		
land 2	d 2 should be filed within the and Mental Hygiene. 7 is marked other than traumatic event, the Mental traumatic event.	To Be C	, <i>Maiden</i> Surname N	)		
Mary	ind 2 should be fall and Mental H 27 is marked of r traumatic eve		19a. Informant's Name/Relationship (Type, Print)  Colleen Hostetler  19b. Mailing Address (Street and Number or Run 2558 Fort Hill Rd., Cor			
imore,	Pages 1 and 2 nent of Health 3 ant: If item 27 is ury or other tra		20a. Method of Disposition  1	Date 12/06		City or Town, State Le, PA 15552
Balt	permit. Page: Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licenses  CCO376  22. Name and Address of Facility W. R. Price Formula St., Meyer	meral I	Home, Inc PA 15552	·
	BI		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. LUNG CANCER.			IMOUTH.
	uted 1 ansit	mlner	Due to (or as e consequence of):  b. With Metastasis  Due to (or as a consequence of):			I month.
x 68760,	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriel-transit	Medical Examiner				
D. Box	v requires that the death cert been signed by the attendin should be detached for use	Physician/N	Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did	tobacco use cont	ribute to the cause of death?
s, P.O.	ss that th gned by be detac			1 🗆	Yes 2□No	3 Probably 4 □ Unknown
ecord	aw 2 s t	Completed by		24a. Was perfo	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
a B	F age	S		10		1 □ Yes 25♥ Np
of Vit	Attending Physiclan: nr death. ector: After this certific by the funeral director,	n: To Be	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury et	me 5□Resi	one) dence 6 □Other how injury occurre	
Division of Vital Records,	To the Hospital or Attending Physiclan: Within 24 hours efter death.  To the Funeral Director After this certific completely filled in by the funeral director.	Certification:	2 Accident M 1 Yes 2 No	28f. Location (3 City or To		r or Rural Route Number,
	he Hospita n 24 hours ne Funere. bletely fille	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the red at the time,	cause(s) and man date and place, ar	ner as steted. nd due to the cause(s)
	To t	Σ	29b. Signatyre and title of certifier \ 29c. License number			(Month, Day, Year)
	2		SABAHAT NAWAB, 32 Corporate DR, Box 265, Grant:	sville	MD.Z	1536.
	Sta Registr		31. Date filed (Month, Day, Year)  AUG  32. Registrar's Signature	- 1/1	1 /	

DHMH 17 Rev 1/2001

Registrar

AUG

1 2006

			1 - For State Registrar	State of Mai	ryland		rtment tificate			ınd Me		iene	0.6	25861
	Physici	V 6	1. Decedent's Name (First, Middle, Last) ALVAH F.	CASH							2. Date of Deat Month August	Day 1, 20	Year 06	3. Time of Death 10:07 AM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City,	Town, or	Location o		1119000	4c. County		
1	mant de d		Union Hospital					Lktor				Ce	cil	
	Funeral Director		221-16-7755	X S	(In yrs. Ia 80	ast birthday) Yrs.	If Under Months	Days	If Under : Hours	Min	B. Date of Birth (Month, Day, ept. 3,	1925		place (State or Foreign ntry) ryland
	and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside City Limits
	Mary I sho	tor	Delaware Sussex		Se	aford								1XYes 2 No
	with the sa or 28s	i Directo	10e. Street and Number 518 N. Willey St				10f. Zip	Code L9973	3		1	0g. Citizen of V US	Vhat Cou	ntry?
350	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "natural", or Items 23s or 28s-f show event. If a Medical Examination must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		k, White	ican Indian, , etc. nite
21215-0036	72 hou	ted	15. Decedent's Edu (Specify only highest grade			16a. Deced	ient's Usua kind of wor	I Occupa	ition	of working	7	16b. Kind of B	siness/Ir	ndustry
7	Aithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		life. L	OO NOT us	e retired,	)	or working	<b>,</b>	ai '	7	
2	filled w Hygiel other ti	Col	17. Father's Name (First, Middle, Last)	2		Bu	iyer		18. Mothe	r's Name /	First, Middle, M	Chemie		
Maryland	should be filed withir nd Mental Hygiene. marked other then imatic event, I'm	To Be	Raymond M. France	2							Shores		,	
ary	shoul ind Ma i marl umati	Ĕ	19a. Informant's Name/Relationship (Ty		17	19b. Mailin	g Address	(Street a	nd Numbe		Route Number	City or Town,	State, Zi	p Code)
	and 2 valth a n 27 is		Richard Vance - Co	usin		100 5	Stratt	on (	Circle	e, El	kton, M	1D 2192	1	
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic e <u>ence.</u>		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Do ation 5 ☐ Oth (Specify)	emoval from State	Odď	ace of Dispo metery cren Fello	sition (Nan natory or of WS CE	ne of ther place EMETE	ery	08/04		Seafor		
Bait	permit. Departr Imports eny inju		21. Signature of Europeans vice dons	ton		22 C I	ranst O Bo	d Addres	of Facility Tunera 57, Se	al Ho eafor	me d, DE l	9973		
8/60,	The law requires that the death certificate be executed at the death certificate be executed at the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sometially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	Due to (or as a	sclu consequ consequ	ence of):	H	'ear	f Dis	æse				Inferval Between Onset and Death UNKNOWN
P.O. Box 6	it the death certific by the attending p tached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal	death 3	Ectopic pro Other (sp					23d. Da	e of deliv	rery Day Year
	w requires that been signed by should be deta	by	Part II. Dther significant conditions cor	tributing to death but	not resu	ilting in the ui	nderlying ca	ause give	en in Part I.			pacco use conf	ribute to	the cause of death? bably 4 Junknown
Hecords,	ysician: The law re is certificate has bee director, page 2 sho	Completed									24a. Was a autops perform	y neda	Were autorior to codeath?	opsy findings available ompletion of cause of 2 No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:				Othe			(Check only on			
o	E ==	To I	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Inpatien		ER/Outpatien 28b. Time of			4 - 140		e 5 Reside			fy)
Ö	nding th. : After	tion	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	Year)	Injury	м	8c. Injury Work	(? Yes 2 □ I			,,		
Division of Vital	흐흑흑=	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At hor (Specify,	me, farm, str	eet, factory	, office		28	31. Location (St City or Town	reet and Numb n, State)	er or Rur	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Physical Cartifier 2 Medical Examination	sician: To the best of ner: On the basis of e and manner state	xamınati	wledge, death ion and/or in	occurred vestigation,	at the tim , in my or	e, date an pinion, dea	d place, ar th occurred	nd due to the ca	ause(s) and ma ate and place,	inner as : and due !	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title certifier				290	. License	number		2	9d. Date signe	d (Month)	Day, Year)
	"CD		> Scielics	en S.MI				1)00	0233	523		8/2	106	•
	Da		30. Name and address of person who co	mpleted cause of dea	8 /	23a) (Type,	Print) Sf Sc	ute	3B,	Ee	eton P	1021	92/	•
122.00	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 2 2	32. Registrar			bark	,						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 25862 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 553 Bernice Clausser Juli 30 /Medical 4b. City, Town, or Locetion of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner lambridge Dorchester 405Dital Dove (seneral If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Days Months Hours 1 □ M 2 🛛 F 96 Director Oct. 8,1909 Minnesota 220-52-7743 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "naturel; or Items 23e or 28e-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Hurlock Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 USA 3806 Wrights Wharf Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Switchboard Operator 8 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Louise Frazier Edward Adler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 3806 Wrights Wharf Road, Hurlock, Maryland 21643 Andrew E. Clausser/Son other 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cemetery 8/2/2006 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tur of Fur eral Service Lice see 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207 eu East New Market, Maryland 21631 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final 2 weeks disease or condition resulting in death) break Examiner Due to (or as a consequence of) Physician/Medical Examiner attending physician end if for use es the bunal-transit or Attending Physician: The law requires that the daath certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detach 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ð 24a. Was an autopsy performed? 24b. Were autopsy findings Completed completion of cause of death? certificate has b director, paga 2 s 1\_ Yes 25 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this if Director: After this od in by the funeral d 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completaly filled in by 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 50804 MD 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M.D. 408 Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State

Registrar

2 2006

Edward Bennett Douglas

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certificat	e of D	eath		R	eg. No.	006	2586
Physicia	an/	Decedent's Name (First, Midd	le,Last)					2. Date of Dea Month	Day Year		ime of Death
Medical Exami	ner		Douglas, IV					July 27, 2	006		045 hrs
		4a. Facility Name (if not institution Suburban Hospital	on, give street and number)			city, Town, or lethesda	Location of De	eath	4c. County of Montgom		
	-	5. Social Security Number	6 Sex 7. Age	e (In yrs. last birtho		Under 1 Year	If Under 24	IHrs 8 Date of Bir	th (MM/DD/YYYY)		e (State or
Funeral Director					N	Months Days		Min.	· ·	Foreign Country)	
	- }	579-08-5877 Usual Residence of Decedent	1XM 2F	24	Yrs.			06-29	9-1982	O an inity /	MD
su's	ŀ	10a State 10b. County		10c. City, Town or	Location					10d	Inside City Limits
ž .	_	MD Princ	e Georges	Capito	ol He	ights				1 X	Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number	0 0001800	- Cap I I		f. Zip Code		1	0g Citizen of Wha	at Country?	
th the Maryland 23a or 28a-f sho notified at once	Ë	172 Daimler D	rive			207	743		United	d Stat	es
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she maric event, the Medical Examiner must be notified at once	era	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.				(Specify Yes or No erto Rican, etc.)	- 14. Race - White,	- American In	ndian, Black,
or ite	Funeral	4	1 Yes 2	X No				erto Moari, etc.)			1
s after ral",	<u></u>		vorced If Yes, Give Year or Dates:	-1-1-10 I 4C- D		s 2 X No		atal. dana	Specify:	B1a	
hour 'natu	Completed	<ol> <li>Decedent's Education (Specific Elementary/Secondary (0-12)</li> </ol>		du		Isual Occupati of working life.			16b. Kind of Bus	messingusi	ır y
5-0036 led within 72 tygiene other than '	림	12	Joneyo (1 1 or e	,	Chef				Priva	ate/Di	ner
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	녌	17. Father's Name (First, Middle	t, Last)			1	18.Mother's N	ame (First, Middle, I		•	
1215 Id be file fental H narked c	Be (	Edward B. Do	uglas, III				Luci	etia Barl	ksdale		
2121 hould be f and Mental is marked stic event,	은	19a. Informant's Name/Relation	ship (Type, Print )	19b.	Mailing Ad	dress (Stree	t and Number	or Rural Route Nur	nber, City or Town	, State, Zip (	Code)
e, MD 1 and 2 shou Health and item 27 is retraumatic		Lucretia Doug	las/Mother					Capitol I			
		20a. Method of Disposition  1 X Burial 2 Crematio	n 3 Removal from Sta	20b. Place of cremator	Disposition y or other p		netery,	Date	20c. Location -	City or Town	n, State
Baltimore, permit Pages I at Department of Het Important: If ite		4 Donation 5 Other S	pecify:	1	nco1n	Cemet	ery 0	8-03-06	Brentw	rood. 1	MD
Balt Departi Import		21. Signature of Funeral Service	Licensee	/	22. Name	e and Address	of Facility S	trickland	Funeral	Serv	ices, P.A
_ ===:	-	23a. Part I. Enter the disease, o	onckla	the death Do not	6500	Allen	town R	oad, Camp	Springs	$MD_2$	20748 proximate Interval
Physician /Medical		failure. List only one cause	e on each line				odor do odran	ac or reopiratory arr	cor, or local, or rica	Be	etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot wound  Due to (or as a conse		ignt arm	1				-+	
		Sequentially list conditions,	b	, ,							
	je	if any, leading to immediate	Due to (or as a conse	equence of):						00	
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
scuted and transi			d								
1760, fricate be executed g physician and the burial - transit	gi	UNPENDED	AMENDED								
Box 68760, e death certificate b the attending physical for use as the but		IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes, outcon		Fetal o	leeth 3	Ectopic pre	anancy	23d. Date of o	delivery Day	Year
Sox 687 leath certific e attending   for use as t	Physician	past 12 months?		time of death 5		(Specify)		ognanoy	None	Day	1001
Boy e death the att	ıysı	1 Yes 2 No 9 Ur	lknown 9 Unknown								
.O. hat the ed by letach	by P	Part II. Other significant condi	tions contributing to death	but not resulting	n the unde	rlying cause g	iven in Part I.		bacco use contrib	_	
S, P.C. Lires that a signed of the deta	pa pa				<del>.</del>			-	2 No 3		
ords, w requir s been s should t	Completed							24a. Was autor	sy pr	nor to comple	findings available etion of cause of
Reco	틩							perfo 1 <b>Y</b> es		eath? ✓ Yes	2 No
tal Rec cian: The certificate ector, page	BeC	25. Was case referred to medical examiner?			··········	26.Place	of Death (Ch	eck only one)			
Vit hysical this o	To E	1 <b>✓</b> Yes 2 No	-	nt 2 🗸 ER/Out		DOA		ursing Home 5	Residence 6	Other.	
fing Ph After t		27. Manner of Death  1 Natural 5 Dear	28a. Date of Inju (Month, Day, Y Jul 26, 2006		me of Injury ars		ry at Work?	Subject was	how injury occurre s shot by polic		
Sior Attend r death ector; by the	ä	Per	estigation				res 2 ✔ No		0	- D - I D	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the state death.  "I Director: After this certificate has been signed by left in by the funeral director, page 2 should be detaced.	Certification:	det	ild not be	jury - At home, farr	n, street, ta	actory, office b	ullaing, etc.	or Town, S	State)		Seet Pleasant
E 5 5 E		4 Momicide	Physician: To the best of m			at the time de	to and place	<del></del>			Seat Pleasant
To the How within 24 h To the Full completely	Medical		aminer: On the basis of exam								se(s)
To with Con	Me	29b. Signature and title of certif	and manner stated er			29c. Licens	e number		29d. Date signe	d (Month, D	Pay, Year)
		hing his	mis			O.C.I	M.E.		July 27, 200	)6	
. 0		30. Name and address of perso	n who completed cause of d	eath (Item 23a)							
CKU		Ling Li, MD Assista	ant Medical Examine	r 111 Penn	Street, I	Baltimore,	MD 21201				19
	tate	31. Date filed (Month, Day, Year		r's Signature	- 10						
Regis	_///	AUG 0 2	2006 Marie	-							
DHIMH T/ Rev T/Z	100			ORI	JINAL						

		1 - For State Registrar		Marylan				lealth a	ind M		g. No	06	25	864
Physic		Decedent's Name (First, Middle, and a second s	Last) Roy Hart	rison Dve	e Jr					2. Date of Deat Month Augus	Day at 04, 200	Year	3. Time (	of Death  O A, M
/Med Exami		4a. Facility Name (If not institution, g			.,	4b. City	, Town, or	Location o	f Death	114841	4c. Count			0 1 1 1
LAdill	iliei		64 Jackson Str						nacor	ning		Alle	gany	
Funeral			. Sex, 7.		last birthday)		er 1 Year	If Under a	24 Hrs.	8. Date of Birth (Month, Day,	Vanel	9. Birth	place (State	or Foreign
Director		214-64-1044	1 <b>X</b> M 2□F	50	Yrs.	Months	Days	Hours	Min.	November (	4, 1955	W	est Virg	inia
D >		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	nastica							10d. Inside (	City Limite
DalfilmOfe, Mary land a Lale Deboso  permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Madical Evaninar must be notified at any once.	ō		llogony.	100.01	y, 10 mil Ol E	ocation	ī	00000	ina					s 2 No
the A	Director	Maryland Al	llegany			10f 7	ip Code	_onacor	iing	1/	g. Citizen of	What Cou	intru?	
with a or	ā		ckson Street			101.2	,p 0000	21539	)		y. Onizon or	U.S.	-	
deeth ms 2;	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.	Was Dece	edent of H			ecify Yes or No- Rican, etc.)		ce - Amer	ican Indian,	
or ite	Fur	1 Never Married 2 Married	Armed Force				. /		, Puerto	Rican, etc.)		ack, White	, etc.	
Paris 2	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 Tes	200 No	Specify:			Speci	ty:	White	
72 h	etec	15. Decedent's (Specify only highest			16a. Dece (Give	kind of w	ork done o	during most	of worki	ing	6b. Kind of E	Business/li	ndustry	
Mary iarna 4 1.4 15-0050 ud 2 should be filed within 72 hours af th and Mental Hygiene. Z is marked other than "natural", or treumatic event, the Medical Event	Be Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	DO NOT		n Laborer				Constr	uction	
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d be d be d be d be d be d be d be d be	o Be		Roy H. Dye,	Sr.							ouise Fo			
and Men and Men is marke	2	19a. Informant's Name/Relationship			19b. Maili	ing Addres	s (Street a	and Numbe	r or Rura	al Route Number,			p Code)	
and 2 and 2 and 2 n alth al		Patricia Wrig	ght - Sister				64 Jack	cson Str	eet, L	onaconing,	Marylan	d, 2153	19	
of Heg		20a. Method of Disposition			lace of Dispo emetery, cre	osition (Na	ame of	(a)			Oc. Location	- City or T	own, State	
DESTRIBUTED, Commit. Pages 1 ar Department of Hear mportent: if Item in highly or other page.		1. Burial 2 Cremation 3 4 Donation 5 Other (Spe		ite		Hill Ce		1	А	ugust 08, 2006	Lona	coning,	Marylai	nd
Dall! permit. 1 Departm importe any inju		21. Signature of Funeral Service Lic	censee		2:	2. Name a	nd Addres	ss of Facility	y Mo	Kenzie Fun	aral Ham	D A		
0 99558		Janos E. M	Marie,		1		8 Ea	ast Mair	n Stre	et, Lonacon	ing. Mar	vland.	21539	
Physician /Medical Examiner		23a. Part I Enter the disease, or constitution of the constitution	a. Due to (or	15 th	uence of):	ter the mo	de of dyin	10	n C		st,	•	Approxima Interval Be Onset and	etween
ficate be executed physicien and is the burlal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequ			10539	× 4000000000000000000000000000000000000	Dr - 2221					
It the death certifics by the attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	2 ☐ Fetal tat time of de	death 3	⊒Ectopic p ⊒ Other (s						ate of delive	very Day	Year
- E B B	ğ	Part II. Other significant condition:	s contributing to deat	h but not resi	ulting in the u	inderlying	cause give	en in Part I.			acco use con s 2 No	ntribute to 3 ☐ Pro	- 01	death? Unknown
	Completed									24a. Was ar autopsy perform 1 Yes 2	1	Were aut prior to co death? 1 \( \sum \text{Yes}	opsy finding ompletion of 2 No	s available cause of
ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:						-	Check only one	-			
this r	7	1 Yes 2 No	28a. Date of I		ER/Outpaties 28b. Time o			4 🗀 1401		me 5 Reside			ity)	
After funer	ion	1 Matural 5 Pending	(Month,	Day Year)	Injury	M	28c. Injury Work	γαι k? Yes 2.∐.N		28d. Describe ho	w injury occu	rrea		
Atten	Certification:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide	t be 28e. Place of	Injury - At ho etc. (Specify	ome, farm, st			.03 2		28f. Location (Str City or Town		ber or Rui	al Route Nu	m <i>ber</i> ,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai (	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the be caminer: On the basis and manner	s of examina	wledge, deat tion and/or in	h occurred evestigatio	d at the tim n, in my op	ne, date and pinion, deat	d place, a	and due to the ca ed at the time, da	use(s) and m te and place,	anner as and due	stated. to the cause	(s)
To the within 2 To the complet	Ž	29b. Signature and title of certifier	1/0	4 .		29	c. License	e number		29	d. Date signe	ed (Month,	Dey, Year)	
		1/	uggone	1 mx	2			23	218	21 /	tu64:	st c	14 20	06
•		30. Name and address of person wh	no completed cause of	of death (Item	23a) (Type,	Print)	1	,	1	1 22	7464.		1	<u> </u>
,		bary Wagonee	MD 49	15 Jer	ton D	rive	, 641	most	and	1/10	X150	2	·	
St Regis	tate trar	31. Date filed (Month, Day, Year)	7 2006 N	strar's Signa	nure All	Anan	63 0		,					

			State of Maryland / De	partment of Health and M	_	ne .	OFOCE
		1	1 - Stata Registrar  Co	ertificate of Death	Reg	No.2 0 0 6	20000
×	Dhysisi	187	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death
	Physicia /Medic	al	Charles Henry Davis, Jr.	4b, City, Town, or Location of Death	July_	28 2006 4c. County of Death	1900 M
3,0	Examin	er	4a. Facility Name (If not institution, give street and number)	Cheverly			George's
	Funeral	***	Prince George's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9 Birthr	place (State or Foreign
Page	Director		577-22-8002 1\(\mathbb{T}\) M 2□F 86 Yrs.	Months Days Hours Min.	Dec. 16,		sh., DC
	and w	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryli e o o	힏	DC	Washingto	on		1X∏ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	th with		#3 - 16th St., NE	20002		United S	
	r dea	neu		<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	etc.
36	rs afte	by Funeral	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give 1 Year or Dates:	1 ☐ Yes 2√ No Specify:		Specify:	rican erican
9	within 72 hours after death with the Maryland ane. than "netural", or Items 23a or 28a-f ehow ha Macigal Examinar must be notified at	ted	15. Decedent's Education 16a. De	pedent's Usual Occupation we kind of work done during most of work		b. Kind of Business/Ir	
215	thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	DO NOT use retired)	ng		
21	led wi		12th  17. Father's Name (First, Middle, Last)	Supervisor	(First, Middle, Ma	DC Govern	ment
and	ntal Hed ot	Be	Charles Henry Davis, Sr.	10. Would S Name	Martha	_	
Maryland 21215-0036	should nd Me mark mark	2		illing Address (Street and Number or Rura			c Code)
	alth a		Inez Davis/Sister	#3 - 16th St., NE	Wash., D	C 20002-65	509
ore,	es 1 a of He of Hem f Item r othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Discemetery, Communication 1	position (Name of rematory or othe Property)	Date 20	c. Location - City or T	own, State
Ë	ment tent: I		4 Donation 5 Other (Specify) Marylar	d National Mem. 8/			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural; or Items 23a or 28a-f show apprintury or other traumatic event, Ita Madical Examinal must be notified at ODGs.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility S: 4001 Benning		neral Home	
	den to		23a. Part1. Enjel the disease, or complications that caused the death. Do not				Approximate Interval Between
	Physician		shock, or negart failure. List only one cause on each line.	EROME CARDIOVA			Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	EXOUS CHIEBIET AS	3000	713000	years -
	Examiner		Sequentially list conditions, b.				
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed iicien and burial-transif	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
760,	0 0	cai	d				
99	tifica ig ph as th	Physician/Medi	IF FEMALE:				
Вох	aath cer attendin for use	lan/	23b. Was decedent pregnant  1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	rery Day Year
o.	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	Olifer (specify)			
S, P	res that the de signed by the a be detached t	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	e undertying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w require been sig should b	ed b	ENCEPHALOPATRY ANEMI		1 ☐ Yes	2□No 3□Pro	bably 4 (Unknown
of Vital Record	The law requires that the site has been signed by the bage 2 should be detache	Completed	multiple stage 4 Decus.	tus viceres	24a. Was an autopsy	prior to ce	opsy findings available ompletion of cause of
E R		Con	Respiratory Failure Venti		performe 1 Tes 2	No 1 ☐ Yes	2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Other	h (Check only one)	ce 6 ☐Other (Spec	.6.1
	g Phys ar this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how		(19)
ion	Attending death. ctor: Aft y the fun	atio	2 Accident investigation	M 1 Yes 2 No			
Division	of attending Peter death. I Director: After I din by the funers	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number.
٥	Hospitel or Attending 14 hours effer death. Funerel Director: After tely filled in by the fune		29a. Certifier 1 Cartifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place	and due to the cau	se(s) and manner as	stated.
		edical	(Check only one) 2 Medical Examiner: On the basis of examination and/one)				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	. Day, Year)
	2		Marllen Work in	101832	2	9 July 2	006
2	(5)		30. Name and address of person who completed cause of death (Item 23a) (Ty	29c. License number DOISS2  De. Print) Overnshung Ro	Hyat	TSVILLE M.	7 20781
4	St	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature	CE DECHIONOLY ICC	1 . /		
	Regist		31. Date filed (Month, Day, Year)  AUF 0 2 2006	ule			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** JULY 2006 2:14P M HELEN LOUISE DIGSBY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 M XXF Yrs 1918 SOUTH CAROLINA Director 221 16 3299 88 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "neturel", or Itema 23a or 28a-f show the Medical Examiner result be neithed at XX Yes 2 □ No Director MD PRINCE GEORGES TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 UNITED STATES 4412 23RD PLACE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK δ 3 ☐ Widowed XX Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **HOUSEWIFE** NONE 6TH of Health and Mental Hygie item 27 is marked other t r other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOUISE TOWNS FRANKLIN WHITTEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 4412 23RD PLACE MARY GASKINS / DAUGHTER TEMPLE HILLS, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H important: if ite eny injury or ot once. XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 7/28/06 SUITLAND, MD of Funeral Service 21. Signatur 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 ter the disease, or complications that caused the death. heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate vuse (Final disease or condition resulting in death) Physician Meno /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical 8 attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy in the past 12 months Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ M been signed by the a should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 1 Yes 2 1 NO or Attending Physician: To Be 25. Was case referred to me examiner? 26. Place of Death (Check only one) 1 Tes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1.2 In patient 2 3 N 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; Division 1 \* atural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Positiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie pletee cause of death (Item 23a) (Type, Print) 30. Name and address of person enpri AUC 3-4/8/1 wes arastoo 380/C 31. Date filed (Month, Day, Ye 32. Registrar's Sign State 28 2006

DHMH 17 Rev 1/2001

Registrar

JUL

State of Maryland / Department of Health and Mental Hygiene

		State of Maryla	Certificate			1. No.	6 2	5867
		Decedent's Name (First, Middle, Lest)			2. Date of Death Month	Day Ye		me of Death
4	Physician /Medical	Alyce Doyle			July 28			40am
	Examiner	4a Facility Name (If not institution, give street end number)		4b. City, Town, or L		4c. County of D	eath	-roam-
Ĺ.,	* ' - '	Manor Care Nursing Home		Chevy Cha		Montgo		
	Funeral	1 □ M 2 □ X F	s. last birthday) If Under 1 Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, )	'ear) 9.	Birthplace (S. Country)	tate or Foreign
	Director	319-01-4822 95 Usual Residence of Decedent	Yrs.		10-14,1	910 N	orway,	MT
	Jend		ity, Town or Location				10d. Insi	ide City Limits
	Many First	MD Montgomery C	horry Chasa				1 😾	Yes 2□No
	128a Irec	10e. Street and Number	hevy Chase 10f. Zip Co		109	g. Citizen of What	Country?	
	vuid be filed within 72 hours after death with the Mai Mentel Hygiene. Inted other than "netural", or items 23s or 28s-1 s afte event, the Medical Examiner must be notified. To Be Completed by Funeral Director	8700 Jones Mill Rd	2081	5		United	states	
	deat	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U,S. 13. Was Deceden	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-		American India Vhite, etc.	an,
20	or h	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 250		,,	Specify: W		
21215-0020	ural,	3 ½ Widowed 4 □ Divorced Year or Dates:						
<del>ਨ</del>	n 72 "net edic	15. Decedent's Education (Specify only highest grede completed)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use i	ccupation one during most of worl etired)	king	8b. Kind of Busine	ess/industry	
212	than than	Elernentary/Secondary (0-12) College (1-4or 5+)	Homemaker	,		Home		
פַ	ent,	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, Ma	iden Surname)		
<u> a</u>	Aente Aente de tre e tre	Camile DeMaeyer		Elodi Ge	1dmeyer			
ar	s ma	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (S	reet and Number or Ru	rel Route Number, (	City or Town, Stat	te, Zip Code)	
Σ.	end 2 palth 27 i	Denis Doyle/ Son	110 Summerf					
Baltimore, Maryland	2 2 2 2 2 U	20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 20b.	Place of Disposition (Name cemetery, crematory or other	of r place)	Date 20	c. Location - City	or Town, Sta	ite
<u>=</u>	ment of lury or	4 ☐ Donation 5 ☐ Other (Specify) N	ational Crema			alls Ch	urch,V	Α
a D	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mentel Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show eny Injury or other treumatic event, the Medical Examinat must be notified at once.  To Be Completed by Funeral Director	21. Signature Funeral Service Licensee	22. Name and A	ddress of Facility Gawler's S	ons,INC			
_	00 = 0 a	Julian Brown	5130 Wi	sconsin Ave	,N.W. Was	hington	DC 20	016
4		23a. Part1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.	ath. Do not enter the mode o	dying, such as cardiac	or respiratory arres	t,	Interva	ximate al Between and Death
	Physician /Medical	Immediate Cause (Final					. Onsor	and boatin
1	Examiner	disease or condition resulting in death) a.	oke				1	-
	ē ja	Due to	(or as a consequence of):				I	
	The law requires that the deeth certificate be executed as the hes been signed by the attending physician end page 2 should be deteched for use as the buriel-trensit completed by Physician/Medical Examiner	Sequentially list conditions Due to	(or as a consequence of):				I I	
Ö,	ian er uriel-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to the condition of the condi					i	
68760,	ete b hysic the b	Cause Disease of Injury that initiated events resulting in death) Last  Due to (	or as a consequence of):					
Ø X	entifice ling pl ie es t	d					1	
Box	at the deeth ce do by the attendideteched for use							
P.O.	he de ched ched	Part II. Other significant conditions contributing to death but not re	sulting in the underlying caus	e given in Part I.		ecco usa contrib	120	CALL DEL
J.	that t	Advanced Dement	io		1 ☐ Yas	2 □ No 3 □	] Probably	4. Unknown
Records,	r requires that the deeth cer been signed by the attendir should be deteched for use leted by Physician/N				24a. Was an		lb. Were auto	psy findings
<u></u>	The law requireste has been single 2 should Completed				performe	ed?	available p completion of death?	n of cause
Ä	he la e hes age 2				1 Vie	2 🗷 No	1 ☐ Yes	2□ No
ta		25. Was case referred to medical		26. Place of Dea	th (Check only one)			
<u> </u>	Physicien: rthis certific ral director, r. To Be (	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ DOA	Other: 42 Nursing Ho	ome 5 Residen	ce 6 □Other (S	Specify)	
0	g Ph ter th neral	27. Manner of Death 1 Natural 5 Pending 28a. Date of tnjury (Month, Day Year)	28b. Time of 28c.	Injury at Work?	28d. Describe how			
<u> </u>	auth. or: Af he fu	2 ☐ Accident investigation	M	1 ☐ Yes 2 ☐ No				
Division of Vital	tal or Attending P rs efter death. al Director: After t led in by the funers  Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, factory, of ify)	fice	28f. Location (Stre City or Town,		r Rural Route	Number,
	urs el urs el illed i	CO Continue of Continue Developer To the heart of continue						
	To the Hospital or Attending Physithin 24 hours efter death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)						use(s)
	ithin of the omple	29b. Signature and title of certifier	29c. Li	cense number	290	I. Pate signed (M	onth, Day, Ye	ear)
		res	100	005 4 56 6	,   -	12810	6	
	5	30. Name and address of person who completed cause of death (Ite				,		
		Gulitles Blancoville 112 mas 5	withour R.	such, Suit	230, 700	uson '	H172	1286
	State	31. Date filed (Month, Day, Year) 32. Jegistrer's Sign	atura -			/		
	Registrar	AUG 0 2 2006 Anguer	AL ASSET					

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H <i>rtificate of l</i>			ene j. No. 2006	25868
	Physici /Medi		Decedent's Name (First, Middle, Last,     MAUDE	E. DO	YE			2. Date of Death JULY 28	Day 2006 ear	3. Time of Death 8:50 A M
4	Examir		4a. Facility Name (If not institution, give Casey House		<b></b>	4b. City, Town, or Rock V	Location of Death		4c. County of Dea	th GOMERY
	Funeral Director		5. Social Security Number 6. Sec 214-32-8185	7. Age M 2 1	(In yrs. last birthday)	-	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Jan.1,1	O Rie	thplace (State or Foreign ountry) aryland
	Maryland a-f ehow	ctor	Usual Residence of Decedent	omery	10c. City, Town or Lo	ethesda				10d. Inside City Limits 1 ☐X es 2 ☐ No
	th with the 23a or 28	ai Director	10e. Street and Number 10506 West	lake Dri	ve, #102	10f. Zip Code 2 C	817	10g	U.S.A.	-
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or port traumatic event, the Medical Examinar roual be muitted at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 🎎 🛣 ivorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1  Yes X No		pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.
Maryland 21215-0036	within 72 ho iene. then "netur the Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of work	ring	Briens	ndustry  Restauran
and 2	d be filed ental Hygi ced other c event, I	To Be Co	17. Father's Name (First, Middle, Last)  Henry Fuller	_		COOK		e (First, Middle, Ma	uiden Sumame)	
	ind 2 shoul alth and Mi 27 is mari	1	19a. Informant's Name/Relationship (Ty  Joyce Fuller	pe, Print)			nd Number or Rui	ral Route Number, C	City or Town, State, 2	
Baltimore,	Pages 1 ament of Heimont: If Item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State	Jerusale	natory or other place em Churc	h ¢em 8	3/3/06	c. Location - City or	lle, MD
Ball	permit. Depart Import any Inj		21. Signatur Theral Service License	Haor.	telup.	46 N. Wa	shingto	on St.,	Rockvill	CME, P.A. Le, MD 20850
L.	Physician and Medical Examiner as the burial-transit	i Examiner	23a. Part1. Enter the disease, or complishock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	he death. Dof-not ent at a consequence of):  consequence of):  consequence of):	er the mode of dying	, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
P.O. Box 68760,	ath cert attendin for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	w requires that the de been signed by the a should be detached i	þ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	n in Part I.			the cause of death?
Vital Records,	The ate h page	Completed						24a. Was an autopsy performer	prior to d	topsy findings available completion of cause of
<u> </u>	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Otho		h (Check only one)		
Division of	Attending Phys ir death. ector: After this by the funeral dir	ation: To	1  Yes	1 ☐ Inpatien  28a. Date of Injury (Month, Day	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	# 🗆 Nursing no	me 5 Residenc 28d. Describe how		hy)Hospice
DIVIS	2 2 2 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical	one)	nician: To the best of ner: On the basis of e and manner state	my knowledge, death examination and/or inved.	occurred at the time restigation, in my op	e, date and place, inion, death occuri	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	T T P	Σ	29b. Signature and title of certifier	/ An		29c. License		29d.	Date signed (Month	, Day, Year)
7	2		Cynthis m Dell		ab //a = = = =	H005	0002		7-28-06	
			30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type, mesy Flospic s Signature	Print) C 6001 M	uncaster i	Mill Red K	ockville, A	10 20852
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 0 2 2	32. Registrar	s signature	meli)				

			1 - For State Registrar	State of M	Marylar				lealth and Death		F	leg. No.	2006	2586	5 9
	Physici	an	Decedent's Name (First, Middle, L	.ast)						2	. Date of Dea Month	Day		3. Time of Deatl	1
	/Media		JAMES	R		DER	ICKS				July	_3		0910	М
7	Examir	er	4a. Facility Name (If not institution, g				4b. City	, Town, o	Location of Dea	ath	/	4c.	Licenic		
			PENINSULA REGION			ENTER	If I lade	er 1 Year	If Under 24 Hr	·s 0	Data of Bint				-
	Funeral Director		5. Social Security Number 6.  182-24-9849  Usual Residence of Decedent	Sex 7.7 1MM 2□F	77	. last birthday) Yrs.	Months		Hours Mi	n.	Date of Birth (Month, Day ULY 2,	, Year)	Cour	place (State or Fore htry) SYLVANIA	ngn 
	aryland •how		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						1	0d. Inside City Lim	nits
	Mary e e	tor	FLORIDA COLLI	ER		NAPLES								1 □ Yes 2 🔀	No
	128°	Irec	10e. Street and Number		J.			p Code				10g. Citi	zen of What Cour	ntry?	
	h wit	a D	3241 BENICIA C	т.				3410	9				USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heelint and Mental Hygiene. I them 21 is marked other then "naturel", or Heme 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force	s? No		Was Deci		ispanic Origin? ( in, Mexican, Pue	(Specifi erto Ric	fy Yes or No- can, etc.)		14. Race - Americ Black, White,		
ğ	2 hou	ted	15. Decedent's	Education		16a. Deced	lent's Us	ual Occup	ation			16b. Ki	nd of Business/Inc	dustry	
75	within 7. ene. then "n	Completed	(Specify only highest of Elementary/Secondary (0-12)	college (1-40	or 5+1	life. L	DO NOT	use retired	during most of w d)	orking					
5	d with	mo;	Elementary/Secondary (6 12)	2		PAYR	OLL	SUPE	RVISOR			MA	NUFACTUR	ING	
	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, the Me	Be	17. Father's Name (First, Middle, La	st)					18. Mother's N	ame (l	First, Middle,	Maiden	Sumame)		
Maryland	Mental Mental arked o	To E	RAYMON N.	DERICE	KSON				URSUL	A	I	LAYT	ON		
ary	should and Men a marke umatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Addres	is (Street	and Number or F	Ru <i>ral F</i>	Route Numbe	r, City o	r Town, State, Zip	Code)	
	elth a		MARGARET ELLEN D	ERICKSON/V	WIFE	3241	BENI	CIA (	CT., NAP	LES	FLOI	RIDA	34109		
Baltimore,	of He of He fiterr		20a. Method of Disposition 1 □ Burial 2 🕅 Cremation 3			Place of Dispo	sition (Na	ame of		Dat			cation - City or To	own, State	
Ĕ	Pages nent of I int: if It		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		10	EMATORY	-		1	/31,	/06	DEL	MAR, DEL	AWARE	
ä	그분분층 .		21. Signatury of Funeral Service Lic	ense	10	22	. Name a	nd Addre	ss of Facility						
m	Depa Impo any Ir		Slorge M.S	temol	no A	7, н	ASTI	NGS I	FUNERAL	HOM	Æ, SEI	LBYV	ILLE, DE	. 19975	
	Cate be executed by Scienary Physician hypotectical physician and hypotectical physician site of the physician	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Coron Due to (or a	as a consec	Quites uence of):	int y	dis	tion	,				Pars and Death Day 5	
P.O. Box 687	I the death certifi by the attending ached for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta tat time of d	al déath 3☐ death 5☐	Other (s						23d. Date of delive Month	ery Day Year	
ds, I	juires that n signed b uld be det	þ	Part II. Other significant conditions	contributing to death	h but not re:	sulting in the u	nderlying	cause giv	en in Part I.				se contribute to th □ No 3 □ Prob	ne cause of death? bably 4 XUnkno	
		Completed									24a. Was a autop perfor 1 Yes	sy	prior to con death?	psy findings availa mpletion of cause of	ble of
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place of D	eath (	Check only o	ne)			_
<del>o</del>	Physician: r this certifice ral director, i	မ	1 ☐ Yes 2 ☐ XNo	Hospital: 1 XInpa		ER/Outpatien			4   Nursing				6 □Other (Specif	y)	
	ng P fter t inera	ë	27. Manner of Death 1    1    Natural 5 □ Pending	28a. Date of li (Month, i	njury Day Year)	28b. Time of Injury		28c. Injur Wor	y at k?	28	d. Describe h	ow injur	y occurred		
Division	For Attending efter death. Director: After I in by the fune	Certification:	2 ☐ Accident investigat				М	1 🗆	Yes 2 □No						
: <u>≅</u>	or Att	E	3 Suicide 6 Could not determine	286. Place 01	Injury - At h	nome, farm, str <i>ify)</i>	eet, facto	ry, office		28	f. Location (S City or Tow		d Number or Aura )	l Route Number,	
	Italic Irsef ralio									-					
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: Atter this certific completely filled in by the funeral director.	Medicai	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examina	owledge, death ation and/or in	occurre vestigatio	d at the tir n, in my o	ne, date and pla pinion, death oc	ce, and curred	d due to the o at the time, o	ause(s) date and	and manner as si place, and due to	tated. the cause(s)	
	of the office of	Me	29b. Signature and title of certifier	1			2:	9c. Licens	e number		1	29d. Dat	e signed (Month,	Day, Year)	
			) Tis	modes		MD PI	10	0586	89			~	-20-0	1.	
	8,8		30. Name and address of person wh	no completed cause of	of death (Ita	1							-30-0	Q	
1	2/1/1		Tomasz Swierko	C 1	La C	L N .	ς.	11:eL		ر	180				
	Sta	ate	31. Date filed (Month, Day, Year)	32. <b>Be</b> gi	istrar's Sign	nature		+1125	ury, md	, –	_				
.2.	Regist		AUG 02	2006	Occa -	KI	10.01								

			For State Registrar	State	of Maryla		artment of	f Health and of Death	Me		iene	006	25	870
			1. Decedent's Name (First, Mide	dle, Last)					2.	Date of Dea Month	th Day	Yeer	3. Time	of Death
	Physici		Mary	1,2	a .	Dau	150n		J	ulv_	27	2006	8:2	9 PM
	/Medic Examin	4	4a. Facility Name (If not Institution					n, or Location of De		<u> </u>	4c. (	County of Death		
			Genesis Heal	thCare	- The H	Pines	E	aston				Talbo	ot	
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Ye		rs. 8.	Date of Birth (Month, Day	Year)	Co.	untry)	e or Foreign
	Director		220-32-1279	1 M 2 1	6	9 Yrs.	Month of Bu	,0 1.02.0	$\Box D$	ec. 2	919	36 Sou	th Car	olina
_	pu *		Usual Residence of Decedent  10a, State 10b, Count	h/	10c C	ity, Town or Lo	cation						10d Inside	City Limits
	the Maryland 28e-f show	5			700.0	.—	,							es 2 1 No
Y	the M 28e-1	ecto		160+		Ea	5700 10f. Zip Cod	)			O- Citi-	en of What Co		
H	with t	Funeral Director	10e. Street and Number	all Da	a 111		7 /	( ) (			,		unitry :	
13	e 23a	erai	11. Marital Status	CK DO	Secedent Ever in		Nas Decedent	of Hispanic Origin?	(Snecifi	v Yes or No-		1 5 A 4. Race - Amer	ncan Indian	
0	Iteme	un	1 Never Married 2 Ma	Amed	Forces?	i		of Hispanic Origin? Cuban, Mexican, Pu	erto Ric	an, etc.)		Black, White		•
36	Irs aft	by	3 ☑ Widowed 4 ☐ Divorce	If Yes	, Give or Dates:		1 □ Yes 202/1	No Specity:				Specify: B	ack	
215-0036	within 72 hours after death with the ene. ene. then "natural", or lleme 23a or 28e is Medical Exana not must be not	ted	15. Decede	ent's Education		16a. Dece	dent's Usual Oc	cupation			16b. Kin	d of Business/l		
715	7 nin 7. n n	pie	(Specify only high Elementary/Secondary (0-12)	est grade complet	ed) ge (1-4or 5+)	life.	kind of work do DO NOT use re	ne during most of v tired)	vorking	-				
21	filed with Hygiene other the	Completed	3			1400	nema	Ker			SON	leone	15e's	home
	be filed tal Hygi d other	Be	17. Father's Name (First, Middle	e, Last)				18. Mother's N	iame (F	irst, Middle,	Maiden S	Sumame)		
aryland	ould b	Jo E	Joseph	, McK	endr	ick		Cat	ner	rine		happ	nan	
ary	A C E E		19a. Informant's Name/Relation				ng Address (Str	eet and Number or	-		City or	Town, State, Z	ip Code)	244
Z	1 and 2 Health a em 27 is		Maggie	Ross	<u> </u>	7080	Laure	nLape	. Al	4.803	- EC	25tow,	MD.	21601
altimore,			20a. Method of Dispesition 1 ☑ Burial 2 ☐ Cremation	a 2 □ Bomoval fr		Place of Dispo cemetery, crei	sition (Name of natory or other	place)	Date	<b>9</b>	20c. Loc	ation - City	Town, State	
Ē	0 0		'4 □Donation 5 □Other		I State	VYTOW	N Cen	etery 8	121	06/	Fas	ton.M	024/0	Nel
alti	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service	e Licensee	11	22	2. Name and Ad	dress Facility	1 1			7	7	
m	Per gang		Janelle	C. J	Venry	2 H	enry F	uneral thington S	to C	ambr	dar	Mary	land 2	1613
			23a. Party. Enter the disease, shock, or heart failure. Li	or complications that only one cause	nat caused the dea	ath. Do not ent	er the mode of	dying, such as card	iac or re	espiratory arr		/	Approxir Interval	Between
	Physician		Immediate Cause (Final disease or condition	1	leral and	set n	fur cho	אמרי					Onset a	nd Death
	/Medical		resulting in death)	a. Due	to (or as a conse	equence of):							06 64 97	,,,,
	Examiner		Conventially list conditions	b	rdion	Dellet	n. isch	emic					near	5
	n =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	io (or as a co de		1.							
	and e-trans	ami	Cause (Disease or injury that initiated events	c. 6	-	askerty	disca	ese.					year	4
0	te be executed ysician and ie burial-transit		resulting in death) Last	Due	1.11 1.	1000						4		
3760	9 %	lical		d	1 kerossi	20513							422	r.s
39 )	Attending Physicien: The law requires that the death certifical redeath.  ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE:									1	/	
Вох	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	1 🗀 Li	, outcome of pregr ve birth 2 ☐ Fe	tal death 3	Ectopic pregna				23	3d. Date of deli Month	very Day	Year
O. E	ne dea the at hed fo	S	1 □ Yes 2 □ No 9 □ Unknown		regnant at time of nknown	death 5	Other (specify	")				10101101	54,	
P.O.	es that the de igned by the be detached	Phy	Part II. Other significant condi	isiana arratikusir-	40 doodh but oot o	autian in the co		anna in Dad I		220 Did to	haaaa u	e contribute to	the sauce	of stooth?
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o.c	w require been si	ted	1/1/00/04	× 11/20119	700-				-					
Records,	e law has b	nple							_	24a. Was a autops	y	24b. Were au	topsy findin ompletion o	gs available of cause of
=	The	Completed								perfor	2 NNo	death?	2□ No	
Division of Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medic examiner?					26. Place of E						
£	hyei this c	P	1 Yes 2 6			ER/Outpatier	IT 3L DUA					Other (Spec	eify)	
ū	ding Phye	on:	27. Manner of Death  Natural 5 ☐ Pend	anig	late of Injury Month, Day Year)	28b. Time o Injury		njury at Work?	280	I. Describe h	ow injury	occurred		
Sio	death. ctor: A y the fu	Certification:	2 Accident inves	stigation	United States And Advanced And	<u> </u>		1 ☐ Yes 2 ☐ No	206	Logation (C	lenna en el	Alumbas as Ou	and Claude Al	
Ξ	or At after of Direction by	T.	4 Homicide dete	mined   200. F	lace of Injury - At uilding, etc. (Spec	nome, tarm, sti cify)	eet, ractory, on	ice	201.	City or Town		Number or Ru	rai Houte N	umber,
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		Consider Consider	via a Dhyminian T	the best of my kee	soulodes dest		e time, date and pla		I due to the e				
	To the Hospitel within 24 hours a To the Funerel (completely filled	Medical		al Examiner: On the				e time, date and pia ny opinion, death od						Θ(\$)
	thin 2 the mple	Mec	29b. Signature and title of certif		7		29c. Lic	ense number		2	9d. Date	signed (Month	, Day, Year	-)
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			00 N	an unha samulaturi	anuta of dansh /	am 22a) /T	Brint)	V V V 16	1			100	100	
			30. Name and address of person	OLALIZY	M V	6 (C)	DUTCH	MANIS	LAI	Wi-	1-A	STON 1	MA	21601
	C+	ate	31. Date filed (Month, Day, Yea	31)	2. Register's Sign		00101	11/11/1/	17.11			-10,1	1 (	~1001
	Regist			9 1 2008		K	house	1						

			For State Registrar		State o	f Marylaı		artmen rtificat			and M	ental Hyg	giene 2 Reg. No.	2006	25871
- Sec.	, A. Jes	Áq	1. Decedent's Name (First, Mid	dle, Last)							}	2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		Doris		Anne		Eva	ns				July		2006	1133 <sup>M</sup>
	Examin		4a. Facility Name (If not instituti						Town, or l		ol Death		4c. Co	ounty of Dea	th
	**		Anne Arundel	-			In a black of a la		napo.		24 Hrs	0 Date -( Bid			rundel
	Funeral	1	5. Social Security Number 213–22–1682	6. Sex	м 2⊠ F	7. Age (in yrs	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)	C	thplace (State or Foreign ountry)
TOX:	Director	-	Usual Residence of Decedent				-					Sept. 2	23,19	Z4 Ma	ryland
	yland now		10a. State 10b. Coun	ty		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Mar-1 st	ţō	MD An	ne Ai	rundel		Mi11	ersvi	.11e						1 ☐ Yes 2X No
	h the	lrec	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What C	ountry?
	15 will	a	817 Cedar Cro	ft Dı	rive			2	1108			-	Į	USA	
	e ma	Funeral Director	11. Marital Status	1	2. Was Dece Armed Fo	edent Ever in U	J.S. 13.	Was Dece	dent of His	panic Ori	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	- 14	. Race - Ame Black, Whi	erican Indian, te, etc.
36	or it	by Fi	1 ☐ Never Married 2 ☐ Ma 3XXWidowed 4 ☐ Divorce	1	1 ☐ Yes If Yes, Giv	/8		1 🗆 Yes	XXNo	Specify:			S	pecify:	White
21215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or itema 23a or 28a-f show Ita Madical Examinar must be milified at	ed b	15. Decede		Year or D	ates:	16a. Dece	dent's Usu	al Occupat	tion			16h Kind	of Business	Andustry
15	in 72 n "na	Completed	(Specify only high	nest grade	completed)		(Give	kind of wo	rk doné du	irina mosi	t of workii	ng	rob. Killa	01 000111000	viridustry
212	y with	mo	Elementary/Secondary (0-12)	,	Col <b>leg</b> e (1	1-40r 5+)	Cler	k Typ	ist				Dept.	of D	efense
שַ	othe	Be C	17. Father's Name (First, Middle	e, Last)						18. Mothe	r's Name	(First, Middle,			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiens at the master of the marked other transmittent. Or items 23s or 28s-1 show item 27 is marked other transmittent. The Medical Examiner must be notified at	ToE	Archibald H.	Wilso	n					Eliz	abet	h M. Fe	eather	cs	
lan	and to		19a. Informant's Name/Relation	nship <i>(Typ</i>	oe, Print)			•	,			i Route Numbe			Zip Code)
≥,	and ealth m 27		Arthur L. Eva	ns (S	Son)					eet,		water,			
ore	I of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	n 3 □Re	emoval from		Place of Dispo cemetery, crea	matory or o	me of other place	)		ate	20c. Loca	ition - City or	Town, State
Ë	tant:		4 Donation 5 Other	(Specify)			ldwin		_			-2006		Lersvi	11e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, ILIA Magnes.		21. Signature of Funeral Service	J-				851	Annap	OLIS	Roa	Home, E	rills	MD.	21054
127 15			23a. Part1. Enter the disease, shock, or heart lailure. Li	or complic ist only on	cations that c e cause on e	aused the dea	th. Do not en	er the mod	a ol dying	, such as	cardiac o	r respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a		1	YPEV	116	(m)	10	.1				Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a conse	guence pr:	R		10		10.			
Н		_	Sequentially list conditions,	b.	Due to	(or as a conse	(V) (	/)(	74 )41	16	1110	VP		-	
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	D08 (0 )	(OI as a COIISE	querice or).								
_	xecu and	хаг	that initiated events resulting in death) Last	C.	Due to	(or as a conse	quence of):								
8760,	cate be executed physician and the burial-transit	dicai Examiner		l.											
89	ificate g phy as the	edic		u.											
Вох	that the death certific ed by the attending p detached for use as	/M	IF FEMALE: 23b. Was decedent pregnant	23		tcome of pregr		Ectopic p					230	d. Date ol de	livery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No			oirth 2 ☐ Fet nant at time of		Other (sp			_			Month	Day Year
P.0	at the by th tache	hys	9 ☐ Unknown		9L) Onkno	own									
	w requires that the been signed by the should be detache	Completed by Physician/Me	Part II. Other significant condi	itions con	tributing to de	eath but not re	sulting in the u	nderlying (	ause giver	n in Part I.			/		o the cause of death?
Records,	sen s	ted		-								101	Yes 20	No 3□P	robably 4 Unknown
e C	S D S	ple	<del></del>									24a. Was autop	SV /	24b. Were a	utopsy lindings available completion of cause of
E.		Con										perfo 1 ☐ Yes	rmed? 2/□ No	death?	2 □ No
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of	Physician: this certific ral director,	2	1 Yes 2 No				ER/Outpatie			4 🗆 140		ne 5 Resid			ecify)
'n	ding I	lon	27. Manner of Death 1 ☐ Natural 5 ☐ Pend		28a. Date (Mon	th, Day Year)	28b. Time o Injury	M	28c. Injury Work	at ? es 2 □		28d. Describe l	now injury o	occurrea	
isic	Attending r death. ector: After oy the fune	Icat	3 ☐ Suicide 6 ☐ Coul		28e Place	of Injury - At	home, farm, st			62 2		28f Location (5	Street and I	Vumber or B	ural Route Number.
Division	tal or A	Certification:	4 Homicide dete	mined	buildi	ng, etc. (Spec	ify)		y, omos			City or Tov		vain207 07 71	aras riodio reamber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier H Certific (Check only one)	ying Phys al Examin	er: On the b	a best of my kn asis of examin ner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the time	e, date an inion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) ar date and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certi	fier \	1		0	29	c. License	number	1		29d. Date :	signed (Mon	th. Day, Year)
				IU	LUM	r m	(19		105	8 4	10		01	1201	2006
			30. Name and address of person	on who cor	mpleted caus	of ol death (Ite	am 23a) (Type,	Print)		7		An	04.0	1.	M
			100	VVC	1021	U \ / '	7001	1)01	IFY	17	VE	1 [1]	1111	V112	1 1 //
	Sta Registi		31. Date filed (Month, Day, Yea			legistrar's Sign	A L	200	/				*		

State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 10, 2006 Freeland Physician Maggie 5:10 А**.**м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Temple Hills Prince George's 3504 Summit Drive If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth Month, Day, Year) May 13, 1920 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months 237-12-0546 1 □ M 2 🖾 F North Carolina Director Usual Residence of Decedent death with the Maryland Prince George's 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Temple Hills traumatic event, the Medical Examiner must be notified at Maryland 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 2212 Dawn Lane U.S.A. or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Completed by 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Supervisor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esias Hargrove Willie Ann Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Dawn Lane Temple Hills, Maryland 20748 Mr. Gregory E. Frye (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: if ite any injury or ot once. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park July 14, 2006 Landover, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Rollins Funeral Home, Inc. 22. Name and Address of Facility re of Funeyal Service Licensee malley 4339 Hint Place, N.E. Washington, D.C. 20019 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical use as attending | IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached ☐ Yes 2 XNo the 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 XNo 2 XNo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 ☑Other (Specify) Hospital: 1 ☐ Inpatient Caretakers 2 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19431 July 20, 2006 eted cause of death (Item 23a) (Type, Print) 11701 Livingston Road #103 Fort Washington, Maryland 20744 30. Name and address of person who Frank M. Ryan, M.D. 31. Date filed (Month, Day, Year) State JUL 3 1 2006 Registrar

		•	For State Registrar	State	of Marylan		rtment <i>tificate</i>			d Ment		ene (	06	25873
			1. Decedent's Name (First, Middle,	Last)							ate of Death	Day	Year	3. Time of Death
	Physicia		ALICE		JEAN		FOLL						006	5:37 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, 7	Town, or	Location of D	eath		4c. County	of Death	
	_ Admini	•	ATLANTIC GENER	RAL HOSPI	TAL		]	BERL	IN			WO	RCES	TER
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year Days	If Under 24 I	Hrs. 8. De	ete of Birth fonth, Day, Y	(ear)	Cou	place (State or Foreign ntry)
	Director		218-32-9365	1□M 200F	69	Yrs.				JAI	NUARÝ	15,193	7	MARYLAND
P	>	1	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y. Town or Lo	cation							10d. Inside City Limits
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the N	28e-f	Director	MARYLAND WORG	ESIEK		OCEAN	10f. Zip				100	a. Citizen of V	What Cou	ntry?
with	a or							1811				11	SA	
eath	18 23	era	17 STACY CT.	12. Was De	cedent Ever in U.	.S. 13. V	Vas Deced	ent of His	spanic Origin	? (Specify Y	'es or No-	14. Rac	e - Ameri	can Indian,
be filed within 72 hours after death with the Maryland	atal Hygiene ad other than "natural", or items 23a or 28e-f show event, the Medical Exprime toust be notified at	Funerai	1 Never Married 2 Marrie	Armed F	2 🗓 No	1	Yes, spec	ify Cubar	Specify:	uerto Rican	, etc.)		k, White,	
ours a	Exam	d by	3 Widowed 4 Divorced	If Yes, G Year or	Dates:							Specify	***	HITE
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igh i	9.5	Ip I	Elementary/Secondary (0-12)	College	(1-4or 5+)	1	SECRE!					TAN	ITOR	TAT
b b	ygie her ti		12 17. Father's Name (First, Middle, I	ant)			SECKE.		18 Mother's	Name (Firs	t Middle Ma	aiden Suman		IAL
d be fi	and Mental Hygiene. Is marked other than eumatic event, the M	) Be	MATTHEW	.431/	DALLAS					TILDA	., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		LER	
shoule	mark	욘	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address	(Street a	nd Number o	r Rural Rou	te Number, (	City or Town,	State, Zij	Code)
142 i	Ath ar 27 Is r treu		WILLIAM A. FOLI	L/HUSBANI	)	17 S	CACY (	CT.,	OCEAN	PINES	s, MAR	YLAND	2181	1
s + 5	f Hea item othe		20a. Method of Disposition			Place of Dispo	sition (Nam	ne of ther place	,	Date	20	oc. Location -	City or T	own, State
age C	nt: # ry or		1 ☐ Burial 2 【ACremation 4 ☐ Donation 5 ☐ Other (Sp		n State	EMATORY				8/1/06	5	DELMAR	, DE	LAWARE
	Department of Health and Menta Importent: if item 27 is marked any injury or other treumatic ev once.		21. Signature of Funeral Service I	icensee	n moos	Unx			s of Facility					10075
3 %	Q = 29		Morge MIL	mola	1.								, DE	. 19975
			23a. Part1. Exp. the disease, or shock, sheart failure. List	conclications only one cause on	t caused the deat each line.	h. Do not ent	er the mode	e of dying	, such as car	rdiac or resp	oiratory arres	st,		Approximate Interval Between Onset and Death
	ysician	1	Immediate Cause (Final disease or condition	a/	Nyoc	ardi	al	In	far c	tion	_			ande
	Medical caminer		resulting in death)	Due t	o (or as a conseq		_	, t	1					- 2
	(diliii)	1	Sequentially list conditions,	t. Due t	o (or as a cons	Opred	-400	SIDY		_				25/12
pet	nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Gre	29%	- (	6.4	inon					10185
жесп	al-trar	Examiner	that initiated events resulting in death) Last	c Due t	o (or as a conseq			a	and w	<u></u>				10 4133
e pe	physician and the burial-transit	dical		d										
tificat	as th	ledi												-
S E	endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pre	egnancy					te of deliventh	ery Day Year
e dea	the at	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre 9□Uni	gnant at time of d known	death 5□	Other (sp	ecify)						
hatth	detact		Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying ca	ause give	n in Part I.	2	23e. Did toba	 acco use cont	tribute to	the cause of death?
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he lay	e has	Completed								-	autopsy perform	ed?	prior to co death?	ompletion of cause of 2 No
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ysick	is cer direct	To B	examiner?	Hospital: 1 [	Inpatient 2	ER/Outpatier	t 3 00	)A Othe	or: 4 🗆 Nursi	ng Home	5 🗌 Resider	ice 6 Oth	er (Speci	( <b>fy</b> )
2 g	ter th neral		27. Manner of Death  1 Natural 5 ☐ Pendin	/A Ac	te of Injury onth, Day Year)	28b. Time o	2	8c. Injury Work	?		Describe hov	v injury occur	red	
Attending	or: Af he fu	atic	2 ☐ Accident investig	gation			М		res 2 □ No					
or Att	ifter d Direct in by	Certification:	3 Suicide 6 Could a 4 Homicide determ	ined   200. Fla	ce of Injury - At h iding, etc. (Speci	iome, farm, str fy)	eet, factory	r, office			City or Town,		oer or Hur	al Route Number,
DIVISION OF VIGAL MECONDS, F.C. BOX 007 00, To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending p  Completely filled in by the funeral director, page 2 should be detached for use as			g Physicien: To t										
the H	thin 24 the F	Medical	one)  29b. Signature and title of certifie	and ma	anner stated.			. License				d. Date signe		
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^	119		30. Name and address of person	who completed ca	use of death (Iter	m 23a) (Type,	Print)	<u>π</u>	7	1	8		1 .	06 , M
-	7		Deborah (	Convan	DO 1	10449	5 (	) (e	lan Ci	L, K	byk	Ber	-(14	, MD
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			1 - For State Registrar	State of Maryla		nt of Health and te of Death	Mental Hygie	6000	25874
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, La  L S C S U  4a. Fecility Name (If not institution, giv  Membriul	Zannah	7 Fe/	/5 y, Town, or Location of Dea Easton	July 2	Day Yeer 2006 4c. County of Death	,
	Funeral Director		5. Social Security Number  2 18-2 4-6162  Usual Residence of Decedent	ex 7. Age (In yrs	9 Yrs. Months	er 1 Year If Under 24 Hr s Days Hours Mir			place (State or Foreign
	r 28a-f ehow	Irector	10a. State 10b. County  Tall  10e. Street and Number	60+ 10c. c	Easto,	np Code	10g.	Citizen of What Cour	10d. Inside City Limits 1 ☑ Yes 2 ☐ No ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: if Item 27 ie markad other than "natural", or Itame 23a or 28a-f ehow importent: if Item 27 ie markad other than "natural", or Itame 23a or 28a-f ehow yi jolyry or other treumatic event, the Madical Examinar must be notified at ODGs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married	Street Ap 12. Was Decedent Ever in the Armed Forces? 1   Yes 2 (D No If Yes, Give	7.305 J.S.   13. Was Dec If Yes, sp	2/6 0/ edent of Hispanic Origin? ( ecity Cuban, Mexican, Pue 2DINo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	d within 72 hours giene. ir than "natural" ine Madical Ex	Completed b	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)	Year or Dates: ducation ide completed)  College (1-4or 5+)	0	ual Occupation rork done during most of we use retired)  ing Line W	orking	o. Kind of Business/In	adustry  Industry
Maryland ?	2 should be filed and Menta! Hygis ie markad other sumatic event, III	To Be C	17. Father's Name (First, Middle, Last)  Walter  19a. Informant's Name/Relationship (	McDaniel		18. Mother's Na R C C Street and Number or F	hel Ba	den Sumame)  1 /e /	Codel
	Pages 1 and 2: nent of Heelth ar int: If Item 27 ie iry or other treu		20a. Method of Disposition  1	Removal from State	Place of Disposition (Nacemetery, crematory or	ame of other place)	Apt. 403	FaStoN Location - City of To	MD, 21601
Baltimore	permit. Pag Depertment: Importent: I any injury o		21. Signature of Funeral Service Licer	C. Henry	510W	and Address of Facility Y FUNERAL ashinatons	to Cambric	lge, MD.	21613
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Records, P.	w requires that been signed to should be deta	þ	Part II. Other significant conditions o	ontributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
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ion of Vi	Jing Afte fune	ToB	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	0.	ath Check only one  Home 5 Residence  28d. Describe how in		y)
Division	To the Hospitei or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	building, etc. (Speci	fy)		281. Location (Street City or Town, Sta	ate)	
	the Hosi hin 24 ho the Fun mpletely f	Medical	29a. Certifier (Check ordy one)  1	ysician: To the best of my kni tinar: On the basis of examina and manner stated.	ation and/or investigation	d at the time, date and place, in my opinion, death occurrence.	urred at the time, date a	and place, and due to	the cause(s)
	To To		1 Jun	De Ale	Il	D005311		Date signed (Month, I	
-			30. Name and address of person who of Dr. Dennis DeShie	lds, 219 S. W	ashington S	t., Easton M	D 21601	,	
36	Sta Registr		31. Date filed (Month Pay, Year) 2	32 Aegistrar's Sign		,			

			1 - For State Registrar	State	of Marylan		artment of H		nd Mental I	Hygiene Reg. No.	005	258	375
47	Dhysisi		1. Decedent's Name (First, Middl						2. Date of Month	Death Day	Year	3. Time of I	Death
	Physici /Medic	4	Dawson Gilham						Ju1y	26	2006	17:23	M
	Examin	er	4a. Facility Name (If not institution	-			4b. City, Town, or		Death		inty of Death		
		5	Washington Adv 5. Social Security Number	entist Ho	7. Age (In yrs.	last highday	Takoma If Under 1 Year		24 Hrs. 8. Date of		tgomer	9	Caraina
	Funeral Director		256-22-8282	1 M 2 □ F	81	Yrs.	Months Days	Hours		Day, Year)	At 1 s	place (State or intry) anta, Ga	r-oreign a
			Usual Residence of Decedent		01				000.	2 1724	ACIC	inca, G	1.
	ylanc how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City	
	e Ma	cto	DC		Wa	shingt	on					1X Yes	2   No
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	death with the Maryland ma 23a or 28a-f show most be notified at	ra	4400 19th Plac			0 101	20018		in 2 (Canada Nasa	USA	Race - Amer	iona Indian	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "naturel", or itema 23a or 28a-1 show any injury or other traumatic event, the Mudical Examinat must be invitible at ances.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marria 3 ☒ Widowed 4 ☐ Divorced	Armed F ned 1 ∑ Yes If Yes G	2 No		was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	in? (Specify Yes or Puerto Rican, etc.	) [	Black, White	, etc.	
2-002d	2 hou		15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind o	f Business/I	ndustry	
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Vital	Physician: Th this certificate al director, pag	Bec	25. Was case referred to medica examiner?					26. Place	of Death Check of				
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<b>-</b>	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	Wor	y at k?	28d. Descr	ibe how injury oc	curred		
Vision	tendi leath. lor: A the fu	catl	2 Accident investi	not be				Yes 2 1					
<u> </u>	or At ifter o Direct in by	ertlflcation:	4 Homicide determ	lined 286. Plac	e of Injury - At hiding, etc. (Specif	ome, farm, str fy)	eet, factory, office		City or	on (Street and Nu Town, State)	imber or Hui	al Houte Numb	er.
_	pital ours a eral I	0	29a. Certifier 1X Certifyii	o Physician: To th	as hest of my kno	wledge deat	h occurred at the tre	no dato and	d place, and due to	the cause(s) and	<b>2000</b> 0100	ctated	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical	(Check only 2 Medical one)	ng Physicien: To the Examiner: On the and ma	basis of examination of the basis of examination of the basis of examination of the basis of the	ation and/or in	vestigation, in my o	pinion, deat	h occurred at the til	πe, date and place	ce, and due	to the cause(s)	
	To the P within 24 To the P complete	Me	29b. Signature and title of certifie				29c. Licens	e number		29d. Date sig	ned (Month	, Day, Year)	
	- > - 0		1	+			Do	060	100	07	-28	-06	
)	(2)		30. Name and address of person	who completed cas	use of death (Iter	n 23a) (Type,	Print)		-	<i>f</i>			
_			TAHMING	K AH	MFO,	MDT	600 Carr	011 Av	re Takoma	Park, M	D 209	12	
	Sta		31. Date filed (Month, Day, Year)	200	Registrar's Signa	ature	٠. وم						
	Registi	rar	AUG 0 2 2	1006	en A	600	a)						

4b. City, Town, or Location of Death

Lanham

6:26 PM

Prince George's

**Physician** /Medical Examiner **Funeral** Director GOODMAN LORRAINE
Baltimore, Maryland 21215-0036

For State Registrar

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Evant and Event Department ones.

**Physician** /Medical Examiner

To the Hospital or Attending Phyelcien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5. Social Security Number 6. Sex		(In yrs. last birtl			24 Hrs. 8. D	ate of Birth	9. B	irthplace (State or Foreign
223-11-1506	M 289 F	50 Y	rs. Months	Days Hours	Min. Ju	ne 3, 1	956 Ei	ngland
Usual Residence of Decedent						•		
10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
Maryland Prince G	eorge's			Bowie				1 XYes 2 No
Maryland Prince Go 10e. Street and Number 2208 Bermondsey I 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	20290 2		10f. Zip C			10a. 0	Citizen of What (	Country?
2208 Bermondsey I	Orive			20721			_	
D 11 Market Comme	12. Was Decedent B	Suprin II C	13 Was Doordo		rigin? /Specify \	Yos or No	Englar	nerican Indian,
11. Marital Status 1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 1 N		13. Was Decede	Cuban, Mexicar	n, Puerto Ricar	n, etc.)	Black, Wh	
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:	:		Specify:	Dlagl
15 December 5 day		1.00	Deserted Henri	0		4.01-	V. 1 . ( B	Black
15. Decedent's Educ (Specify only highest grade	cation completed)		Decedent's Usual (Give kind of work life. DO NOT use	done during mos	st of working	160.	Kind of Busines	s/industry
Elementary/Secondary (0-12)	College (1-4or 5-	+)					Dadison	
17. Fathada Nama (First Middle (1991)	4.1.		<i>f</i> ortgage		- d - bb /m	10:11:11	Privat	.e
17. Father's Name (First, Middle, Last)  Emmanuel Mensah				18. Moth		st, Middle, Maide	en Sumame)	
Enlanuer Mensan					Mary A	sirrey		
19a. Informant's Name/Relationship (Typ		19b.	Mailing Address (	Street and Number	er or Rural Rou	ite Number, City	or Town, State,	Zip Code)
Carl D. Goodman	(Husband)	22	208 Bermo	ndsey Di	rive, Bo	owie MD	20721	
20a. Method of Disposition		20b. Place of	Disposition (Name	of er place)	Date	20c.	Location - City o	r Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		eake Cre		8/3/200	6 В	eltsvil]	le, MD
21. Signature of Funeral Service License	90	_		_ ,				vices, P.A.
Sayly							er MD 20	
23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do no	ot enter the mode	of dying, such as	cardiac or resp	oiratory arrest,		Approximate Interval Between
Immediate Cause (Final	Q a c b	· ·	Ca	0	`			Onset and Death
disease or condition resulting in death)	Resp	lure						
	Due to (or as a	consequence o	61 11.	6 00	~ ()		months	
Sequentially list conditions,	Due to (or as a	consequence o	al m	mg a	isco	136		MOD MIN 7
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								10000
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions con	Due to (or as a	consequence o	0:					years.
	220 10 (01 20 0	- osnooquonoo o						
d d						-		
IF FEMALE:								
23b. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth		3 DEctopic preg	nancy			23d. Date of de	,
in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown		5 Other (spec				Month	Day Year
9 □Unknown	3 UTIKTIO WIT							
Part II. Dther significant conditions con	tnbuting to death bu	t not resulting in	the underlying cau	se given in Part I	I. 2	23e. Did tobacco	use contribute	to the cause of death?
possible ser	51 5			,		1 🗌 Yes	2 <b>X</b> No 3□F	Probably 4 Unknown
,	,					24a. Was an	24h Moro s	autonou findinge available
						autopsy performed?	prior to	autopsy findings available completion of cause of
					1	☐ Yes 2 💢	lo 1 ☐ Ye	
25. Was case referred to medical examiner?	agaital: 18			7	e of Death Che	ack only one)		
TE TOS ZXINO	ospital: Inpatier				ursing Home	5 🗌 Residence	6 ☐Other (Sp.	ecify)
	28a. Date of Injun (Month, Day		ime of 280	. Injury at Work?	28d. [	Describe how in	ury occurred	
2 Accident investigation			M	1 Yes 2	No			
3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, fari	m, street, factory, o	office	28f. L	ocation (Street a	and Number or F	Rural Route Number,
27. Manper of Coath 1 Natural 2	ouliding, etc.	. (Opoony)				my or rown, Sta	10/	
29a. Certifier 1 Certifying Phys	ician: To the best o	f my knowledge,	death occurred at	the time, date an	nd place, and di	ue to the caused	s) and manner a	as stated.
(Check only 2 Medical Examinone)	ner: On the basis of and manner stat	examination and	or investigation, ir	my opinion, dea	ath occurred at	the time, date a	nd place, and du	ie to the cause(s)
29b. Signature and title of certifier	-2	^	29c. l	icense number		29d. D	ate signed (Mor	oth, Day, Year)
	alc	af r	MA GW	00 5	807	6 6	1 /	
		J , '		000	0 1 17	Ju	M 20	2006
30. Name and address of person who con	mpleted cause of de				7	Rouse	a(1)	2.7

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUL 3 1 2006

Registrar's Signature

06-05063

# Please Type or Print in Black Indelible Ink

Sioria Ann Gibson	1- For State Certification Registrar Certification	nt of Health and Mental F te of Death	nygierie Reg. No.	2005 2587
Physician/	Decedent's Name (First, Middle, Last)		Date of Death     Month Day	3. Time of Death
Medical Examine	Gloria Ann Gibson  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	July 14, 2006	2337 hrs
	Baltimore-Washington Medical Center	Glen Burnie		Anne Arundel
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24Hr Months Days Hours Mil	_ `	/DD/YYYY) 9. Birthplace (State or Foreign
Director	579-68-1826 1 M 2 X F 56	Yrs.	07/22/1	949 Cowatry DC
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
and show nce.	DC	Washing	gton	1 X Yes 2 No
the Maryland a or 28a-f sh iified at once Director	10e. Street and Number	10f, Zip Code	ľ	izen of What Country?
ith the 23a o	5111 Fitch St., SE #101  11. Marital Status   12. Was Decedent Ever in U.S.   1	20019  3. Was Decedent of Hispanic Origin? ( §		United States  14 Race - American Indian, Black,
er death with 1 , or items 23s r must be not Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puert		White, etc.
safter call, or niner n	or Dates:	1 Yes 2 X No specify:	140	Specify: Black
2 hours "natu	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of Iring most of working life. DO NOT use re		Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	12th	Child Care Provid	der	Self-Employed
filed w filed w I Hygic of othe t, the N		18.Mother's Nam	ne (First, Middle, Maiden	<u> </u>
21215-0036 total be filed within 7 d Mental Hygiene. s marked other than fic event, the Medical To Be Comple	Samuel G. Gibson  19a. Informant's Name/Relationship (Type, Print )  19b.	Mailing Address (Street and Number or	Fannie Ma Rural Route Number, C	
Baltimore, MD 21215-0036  Departic. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Donna C. Bacon/Daughter	5111 Fitch St., SE		
ore, es l an of Heal	1 X Burial 2 Cremation 3 Removal from State cremator	Disposition (Name of cemetery, y or other place)		Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	4 Donation 5 Other Specify: Harmon: 21. Signature of Funeral Service Licensee	y Memorial Park 7,	/24/2006   Stewart Fu	Landover, MD
Balti permit. Departit Importi	21. Signature of Admerial Service Lice Asse	4001 Benning H		
Physician	23a Part I tenter the disease, or complications that caused the death. Do not failure list only one cause on each line.			
/Medical Examiner	Immediate Duse (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):			Death
Ś.	Sequentially fist conditions,  b.			
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
60, ate be executed hysician and eburial - transi	d AMENDED		_	
60, ate be physiciane buria	IF FEMALE: 23c. If yes, outcome of pregnancy		23	d. Date of delivery
687 certific nding page as the	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregr	nancy	Month Day Year
b. Box 687 the death certific by the attending p ched for use as the Physician!	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	000	
		in the underlying cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 ✓ Unknown
ds, F quires een sign			24a Was an	24b. Were autopsy findings available
Records, The law requires, frace has been sig, sage 2 should be			autopsy performed? 1 ✓ Yes 2	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ral Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P		26.Place of Death (Check		No 1 Yes 2 No
Division of Vital Is ours after death ours after death were Director: After this certification by the funeral director. Certification: To Be Contification:	1 Yes 2 No Impatient 2 ER/Out		•	ence 6 Other:
		me of Injury 28c. Injury at Work?  hrs 1 Yes 2 ✔ No	28d. Describe how in Passenger auto	
Division o spital or Attending towns after dark meral Direction: After filled in by the fune filled in by the fune femilians of the femilians	2 Accident Investigation 28e. Place of Injury - At home, fan	m, street, factory, office building, etc.		and Number or Rural Route Number, City
Div ours afte eral Di	3 Suicide 6 Could not be determined (Specify) Major Road / Hig	hway	Rt. 295 N Rt. 100	0E, , Md.
2				
To the Ho within 24 To the Fu completely	and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	Theodor U Vino Ta M.	O.C.M.E.	Jul	y 15, 2006
10 (0)	30. Name and address of person who completed ause of death (Nem 23a)	ner 111 Penn Street, Baltimo	ore MD 21201	
State	Theodore M. King, Jr., MD. Assistant Medical Examin  3.1 Date filed (Month, Day, Year)  3.2 Registrar's Signature	er i i Penn Sueet, Baitimo	DIE, IVID 21201	
Registra		berli		
DHIVIH 17 Rev 1/2001	ORI	GINAL		

DHIMH 17 Rev 1/2001 OCME 2006

			1 - State of Maryland / State of Maryland /	Department of H Certificate of L		ental Hygier Reg. t	7 11 13	25878
	Physicia	an	1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)  GOLD	BERG		Date of Death Month MULY 2	Day Year 2006	3. Time of Death 5:35-P M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death		4c. County of Death	
	Funeral		HEBREW HOME OF GREATER WASHINGTON  5. Social Security Number 6. Sex 7. Age (In yrs. last to	pirthday) If Under 1 Year		B. Date of Birth		place (State or Foreign
	Director		382-05-1339	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea ULY 27,	1915 МТС	HIGAN
	ahow	_		wn or Location				10d. Inside City Limits 1 X Yes 2 ☐ No
	the Ma	recto	MARYLAND MONTGOMERY  10e. Street and Number	ROCK	VILLE	10g. (	Citizen of What Cou	
	ath with	ral DI	6121 MONTROSE ROAD		20852		U.S.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat relative rottling at once.	by Fune	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (Speci n, Mexican, Puerto Ri <i>Specity:</i>	ify Yes or No- can, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	n 72 ho "natur	leted	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	during most of working		. Kind of Business/li	ndustry
212	ed withle	Somp	Elementary/Secondary (0-12) College (1-4or 5+)	NDEPENDENT BR	READ SALESM		BAKE	RY
Maryland	id be file ental Hy ked oth	o Be	17. Father's Name (First, Middle, Last)  LOUIS GOLDBERG		18. Mother's Name (		len Sumame)	
<b>l</b> ary	2 shoul and Miss mari	-	19a. Informant's Name/Relationship (Type, Print)  SHELDON A. GOLDBERG/SON  20	9b. Mailing Address (Street a				
	s 1 and f Health Item 27 other to		20a. Method of Disposition	967 GRACEFIEL of Disposition (Name of tery, crematory or other place	Da	te 20c.	Location - City or T	
Baltimore,	tant: If lury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  NUSACI	H H'ARI CEMET	CERY	· FE	RNDALE, M	IICHIGAN
Bal	Depar Impor any in	l l	21. Signature of Funeral Sarvice Licensee	EDWARD SAGE 1091 ROCKVI	L' FUNERAL	DIRECTIO ROCKVILL	N, INC. E, MARYLA	AND 20852
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the mode of dyin	ig, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   CERE BRO  Due to (or as a consequence)	VASCULA			/	
	Examiner		Sequentially list conditions, if any, leading to immediate b. DIABETO		LITU	5		
	rcuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	,				
,0928	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence	e of):				
9	ertificate ling phy e as the	Medic	IF FEMALE:					
.O. Box	that the death certifi ed by the attending detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death				23d. Date of deliver Month	Day Year
rds, P	The law requires that the tite has been signed by this age 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death? bably 4 □Unknown
Vital Records,		Completed				24a. Was an autopsy performed 1 Yes 2 12	prior to co	opsy findings available ompletion of cause of 2D No
Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatient 3□ DOA Oth	er: 4 Nursing Home		6 ☐Other (Spec	ifv)
n of	ng ffei		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)	D. Time of 28c. Injury Work	y at 28 k?	d. Describe how in		,,,
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, stc. (Specify)		Yes 2 □No	Bl. Location (Street City or Town, St	and Number or Ru	ral Route Number,
Ö	urs afte							
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A empletely filled in by the fu	Medical	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowled   Description on the basis of examination and manner stated.	ge, death occurred at the tin and/or investigation, in my o	ne, date and place, ar pinion, death occurred	d at the time, date a	and place, and due	stated. to the cause(s)
)	Within To Manager 1	)	29b. Signature anglittle of certifier Kelvicius	y M.D. 29c. Licenson	35436	29d. I	Date signed (Month)	Day, Year) 2006
	,		30. Name and address of person who completed cause of death (Item 232	PUCKVIL	LE, HI	200	P52	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 2 2006  AUG 0 2 2006	Spelle				

			For State Registrar	State of N	Maryland /		artment of F		and Me		iene 20	105	25879
			1. Decedent's Neme (First, Middle,	Last)					2	2. Dete of Deat Month	th Day	Year	3. Time of Death
	Physicia /Medic		Margaret Bly Gu	nde						August	07, 2006	)	16 30 PM
	Examin	_	4a. Fecility Name (If not institution,		or)		4b. City, Town, o	r Location o	of Death		4c. County	of Deeth	
			Fort Washington	Hospital			Fort Wash				Prince		
	Funeral			6. Sex 7. / 1 ☐ M 2 ☐ F	Age (In yrs. last b		If Under 1 Year Months Days	If Under 2	Min.	3. Date of Birth (Month, Day)	Year)	Cou	
4	Director		579-18-1253	10 10 20 1	89	Yrs.				January	26, 1917	North	Carolina
	and **	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					1	10d. Inside City Limits
	Aaryli f •ho	ठ	Design	Coorses	Acco	امما							1 ☐ Yes 🎇 No
	the h	Directo	Maryland   Prince	Georges	Acco	RCCE	10f. Zip Code			1	Og. Citizen of \	What Cou	ntry?
	with Ba or		15707 Identina	aton Pond			2060	7			USA		
	me 2%	Funeral	15707 Living  11. Marital Status	ston Road  12. Was Deceder	nt Ever in U.S.	13.	Was Decedent of H	ispanic Orio	gin? (Spec	ify Yes or No-	14. Rac		can Indian,
0	or Ita		1 ☐ Never Married 2 ☐ Marrie	Armed Force	₹No		f Yes, specify Cuba 1 ∐ Yes 2 🛣 No			ican, etc.)		ck, White,	etc.
3	hours after death with the Maryland tural', or Itame 23s or 28s-f show al Execution forcet by notified at	by	3 ∰ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		I∐ 185 ZIXINO	эр <del>в</del> спу:			Specif	': W1	nite
5-0036	d within 72 hours after death with the Marylan jiene. r than "natural", or Itame 23a or 28a-f ehow the Medical Exemitmet mast be notified at	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16	(Give	ient's Usual Occup	during most	t of working	,	16b. Kind of B	usiness/In	dustry
7	within 72 ene. then 'ne'	dr.	Elementary/Secondary (0-12)	College (1-40	or 5+)		DO NOT use retire				Public	Cah	1
2	e filed will Hygien other th		9	ant)		Cai	ateria S			Eiret Middle	Maiden Suman		301
	a la b	Be	17. Father's Name (First, Middle, L							guson	Maideri Surran	10)	
Maryland	should by	ဥ	Gaston Reeves  19a. Informant's Name/Relationsh		10	Ob Mailie	ng Address (Street				City or Town	State Zir	Code)
<u>a</u>	nd 2 shoulth and 27 is mu			/ Son			Persimmon				-		
	Hear Hear the		Edward Gunde  20a. Method of Disposition	7 5011	20b. Place	of Dispo	sition (Name of		Da		20c. Location -		
Baltimore,			1 X Burial 2 ☐ Cremation		10		natory or other pla	A	ugust	25,200€	Arlingt	on	<b>37 Δ</b>
			* 4 □ Donation 5 □ Other (Sp 21. Signator of Funeral Service L		Arling		ational Cer		lv			.011,	VA
g	permit. Departr Importa any inji		the whole	an Mar	1. 4	Ma 41	Name and Addre ttingley-Ga 590 Fenwicl	ardiner k Stree	f Funer	al Home, nardtown	P.A. Marvla	nd 206	550
ď.	=		23a, Pert1. Enter the disease, or	complications that caus	sed the death. D								Approximate
	Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan		shock, or heart failure. List of Immediate Cause (Final	only one cause on each	n line.		,						Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or a	as a consequenc	e of):	wa						a ont
	Examiner			D	2 44 5 0	T	ia						introur
	<u>.</u>	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequenc	o of): ,							13
	bd d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c A	nee	w	-Ot						nthrow
o Î	en af rial-t		resulting in death) Last	Due to (or	as a consequenc	e of):						1	
3760	certificate be executed ding physicien and use as the burial-transit	Physician/Medical	,	d									
Ó	iffic g p	Med	IF FEMALE:	T									
Box	death cer le attendin ed for use	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pregnanc	у			1	te of deliv inth	ery Day Year
0	o o	/sic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4∐Pregnant 9☐Unknowr	t at time of death	5∟	Other (specify) _						•
a.	The law requires that the te has been signed by th age 2 should be detache	Ph	Part II. Other significant condition	ns contributing to death	h but not resulting	n the u	nderiving cause gr	en in Part I.		23e. Did to	bacco use con	tribute to t	the cause of death?
ecords,	ires tha signed d be del	1 by				,	·····, ··· g ······ g··			1 🗆 Y	es 2 🗆 No	3 ☐ Pro	bably 4 Unknown
Š	w require been sig	Completed								24a. Was a	246	More aut	oney findings available
Rec	has has	mpi								autop:	sy	prior to co	opsy findings available ompletion of cause of
				<u> </u>						1 Yes	2. No	1 🗌 Yes	2 □ No
Vital	hysician: The law his certificate has t I director, page 2 s	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Lippa	atient 2 🗆 ER/0	0.45-54	all pos Ott			(Check only or	ne) ence 6 ∐Oth	/Caaa	4.1
Division of	0 - 0	1: To	27. Manner of Death	28a. Date of I	njury 28b	o. Time o					ow injury occur		17/)
o	ding th: Afte	tior	1 Natural 5 Pending 2 Accident investig		Day Yeer)	Injury		rk?  Yes 2. □	No				
<u>s</u>	or Attending Physician: ther death. Director: After this certifica in by the funeral director, in	ifica	3 ☐ Suicide 6 ☐ Could n	ned 286. Place of	Injury - At home,	farm, str	eet, factory, office		2			per or Rur	al Route Number,
á	al or A s after I Direct	Certification:	4 Homicide	building,	etc. (Specify)					City or Tow	n, State)		
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying	g Physician: To the be	est of my knowled	ige, deat	h occurred at the ti	me, date an	nd place, a	nd due to the c	ause(s) and m	anner as	stated.
	n 24 n 24 he Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To t To t	Σ	29b. Signature and title of certifier	1 1 1	\	~ m	29c. Licens	4 6			29d. Date signe	ed (Month, =	Day, Year)
•			► × · ∪ · ,	Meh	nan	V 11.	MI	7	002	94	8-	1 -	2006
			30. Name and address of person v		of death (Item 23a	a) (Type,		1		4			3.4
	A		31. Date filed (Month, Day, Year)	Alikhani	istrar's Signature	vings	iton Rd	Fort	as	hing ton	MD	20	/45
	Sta Regist		AUG - 9 2006		A Signature	-	8)			5.			
100				AND DESCRIPTION OF THE PARTY OF									

**ORIGINAL** 

			For Stata	State	of Marylan					and M		2 1111	5	25880
_			* Registrar			Cei	tificate	e or L	Jeatn	1		eg. No.		20000
	Physicia	an	1. Decedent's Name (First, Middle Alice Mae GROS								2. Date of Dea	Day Y	'ear	3. Time of Death
	/Medic	al					4h Oit.	Favra 24	Lacation	4 Da-4h	August		Death	10:55 a. <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution 201 Buena Vist		umber)		4b. City,		Location o			4c. County of		gton
			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under		8 Date of Birth			place (State or Foreign
	Funeral Director		220-26-5688	1 ☐ M 2 🛣 F	7.5	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Aug. 18	Year) 3, 1930	Cour	cyland
			Usual Residence of Decedent		L						1108 - 10	, 2550		<i>y</i> <u> </u>
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside City Limits
	e Ma	cto	Maryland Was	hington		На	gerst	own						1 XYes 2 No
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itams 23a or 28a-f show event, If a Modic-LEX. Alter in and be multired at	Director	10e. Street and Number 201 Buena Vist	a Avenue			10f. Zip	Code 2174	0		1	0g. Citizen of Wh USA	at Cour	ntry?
	eath	Funerai	11. Marital Status		cedent Ever in U	.S. 13.1	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No-	14. Race -	Americ	can indian,
^	r Itan	Fun	1 ☐ Never Married 2 ☒ Marri	ied 1 ☐ Yes	2 🔀 No	1				i, Puèrto	ecify Yes or No- Rican, etc.)	Black,	White,	
3	alt, o	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	i <b>v</b> e D <b>a</b> tes:		1 ☐ Yes 2	2₽ No	Specify:			Specify:	wh	nite
2	72 ho	Completed	15. Deceden (Specify only higher		1)	16a. Deced	dent's Usua	l Occupa	ation	t of worki	na	16b. Kind of Busi	ness/In	dustry
21215-0036	within 72 ene. than "na	npie	Elementary/Secondary (0-12)		(1-4or 5+)		kind of wor DO NOT us		)		9			
7	ed wiygien ygien ısr th	Cor	7		0	nome	emake	r	40.34.0			her o		nome
Maryland	should be filed wind Mental Hygie imarked othsr tumatic event,	Be	17. Father's Name (First, Middle, Maurice Leroy		Sr.							Maiden Sumame) Diffend		er
Ž	hould d Me mark matic	N <sub>o</sub>	19a. Informant's Name/Relations			19b. Mailir	na Address	(Street a	and Numbe	er or Rura	ul Route Number	, City or Town, St	ate. Zir	Code)
<u>8</u>	id 2 s Ith an 27 is: traus		Jacqueline Plu		ter	1	-					n, Maryl		
စ်	Heal Heal tem 2		20a. Method of Disposition			lace of Dispo emetery, crer					-	20c. Location - Ci		
<u> </u>	ages ent of et: If i		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		i State	dar Lav				8/1	0/06	Hagersto	wn.	Maryland
altımore,	nit. F artme ortar injur		21. Signature of Funeral Service						_ 1				_	
ñ	Maurice Leroy Dunkin, Sr.    Maurice Leroy Dunkin, Sr.   Viola Corine Diffendaffe										21740			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										1	Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	only one sauce on	P30	00	-	(		m	cer			Onset and Death
	/Medical		resulting in death)	a Due to	o (or as a conseq	uence of):	>			0, (,			-	J of Editor
	Examiner		Conventially list conditions	b										
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a consequence of):									
	ecute ind trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	С.	Due to (see a consequence of):									
760,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):											
$\infty$	cate b	dicai		d		_								
ox e	ding g	/Me	IF FEMALE:	23c If yes o	utcome of pregna	ancy						22d Date	né dati d	
Bo	eath certifical attending phy I for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live	birth 2 Feta	I death 3	Ectopic pro					23d. Date of Month		ery Day Year
o	at the de by the a tached	ysic	1  Yes 2  No 9  Unknown	9□ Unk		J. J.	otiloi (api							
٦	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	y Ph	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying ca	ause give	en in Part I		23e. Did tol	bacco use contrib	ute to th	he cause of death?
g	quires n sign	d by									1 🗆 Y	es 2 No 3	☐ Prob	pably 4 Unknown
ecords,	w requires been si should	jete									24a. Wasa		re auto	psy findings available
Re	The la	24a. Was an autopsy performed? 1   Yes 2   No 2   No 2   ER/Outpatient 3   DOA   Cther: 4   Nursing Home   Residence 6   Other (Specify)												
Vital	tificat											2 140		
	ysicia s cer direct											(v)		
to c	g Ph er th	n: T	27. Manner of Seath	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	12	8c. Injury Work	at		28d. escribe ho	ow injury occurred		
0	Attanding F death. ctor: After y the funera	atio	Natural 5 Pendir Pendir Pendir	9	mi, bay roary	injury	М		Yes 2	No				
Division	or Attand after death Director:	ertification:	3 Suicide 6 Could 4 Homicide determ	ined 289. Plac	e of Injury - At h	ome, farm, str	eet, factory	, office			28f. Location (Si City or Town	treet and Number n, State)	o <i>r Rure</i>	al Route Number,
<u> </u>	talorers aft al Di	Cer									_			
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier Certifyir (Check only one)	ng Physician: To the Examiner: On the	basis of examina	owledge, death tion and/or in	occurred a vestigation,	at the tim in my op	ne, date an pinion, dea	d place, a th occurr	and due to the cared at the time, d	ause(s) and mann ate and place, and	er as si	tated. the cause(s)
	thin 2 the mple	Med	29b. Signature and title of certifie	7	nner stated.		29c	. License	number		2	9d. Date signed (	Month,	Dav. Year)
	T × OS			Va.		Δ/		1	216/	17	12	A.10	. 4	8 mal
			20 Normand addition		use of death //-	1 / C	Print		ME	ntl		Lindi	10	01000
			30. Name and address of person		MI). 1	12 -	000	i	(		Hago	a Nitaria	n	M) 2174
	Sta	te	31. Date filed (Month, Day, Year,	32.	Registrar's Signa	ature	OKE	1 -		1)	1000	July 100	11/	110 01170
	Registr		AUG (	8 2006	Registrar's Signa	H. 1	Sperke							

			For State of Maryland / I 1 - State Registrar		irtment of H tificate of L			giene Reg. No.	UUb	25881
	Dhysiai	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic	al	BILLIE SUE GRANGER		Ab City Town and	Lacation of Donath	AUGUST	2	2006 County of Death	6:44AM <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  CHESTER RIVER HOSPITAL CENTER		CHESTER	Location of Death		46. 0	KENT	
	Funeral Director		5. Social Security Number  458–52–8960  6. Sex 1 □ M 2 ▼ 7. Age (In yrs. last bite of the security Number of Number of	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day FEB - 26	h , Year) , 193!	9. Birthp	lace (State or Foreign try) S
land	MG II		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	m or Lo	cation				1	Od. Inside City Limits
Mary	a baili	tor	MD QUEEN ANNE CENT	TREV	ILLE					1 ☐ Yes 2 X No
ith the	or 28,	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citiz	en of What Cour	itry?
eath w	ns 23a	erai	1515 SPANIARD NECK ROAD  11. Marital Status 12. Was Decedent Ever in U.S.	13.1	2161		orify Ves or No.		USA 4. Race - Americ	an Indian
. I. Z. I. JUU.30 within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces? 1 Yes 2 No 1 Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2X No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, White, Specify: WH]	etc.
72 ho	natur	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	(Give	lent's Usual Occupa	luring most of worki	ing	16b. Kin	d of Business/Inc	dustry
within	than "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired			ED.	UCATION	
Filed C	Hygie other ent,	Be Co	12 4 17. Father's Name (First, Middle, Last)	201	IOOL TEAC	18. Mother's Name	(First, Middle,			
uld be	Vental	To B	WELTON SWINDALL			LILLA	MAE SCO	TT		
y IVIGITY IS	alth and P				g Address (Street a					
Dallinore	nent of He ant: If item ary or oth			EAK	sition (Name of natory or other plac E CREMAT I		006		ation - City or To ENSVILLI	
Dall Permit.	Department of Important: If i any injury or one one one one one one one one one one	•	21. Signature of Funeral Service Licensee	FÉ	LLOWS, HEI 08 S. LIB	ERTY ST.,	CENTRE	VILL		
/1	ysician Medical aminer		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)  a	of):	er the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Batween Onset and Death
ou, se executed	physician and s the burial-transit	i Examine	Sequentially list conditions, if any, leading to immediate cause. Lifter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence consequence)  c. Due to (or as a consequence)							
O. DOX 00/00,	certificate has been signed by the attending physi rector, page 2 should be detached for use as the t	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  d.  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy			23	3d. Date of delive Month	ory Day Year
w requires that	n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause give	en in Part I.	23e. Did to	_		ne cause of death?
n e	ite has bee age 2 shou	Completed							24b. Were auto prior to cor death?	psy findings available appletion of cause of
	artifica ictor, p	Be C	25. Was case referred to medical examiner?			26. Place of Death		-		
Of VICE Physician:	this or al dire	2	1 Yes 2200 Hospital: 10 Inpatient 2 ER/O	utpatier		4   Nursing no	me 5 🗌 Resid		Other (Specify	/)
On	th. : After this certifica s funeral director, p	tion:		Injury	28c. Injury Work M 1 []		200. Describe i	iow injury	occured	
DIVISION al or Attending	s after death	Certificati	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f. building, etc. (Specify)	arm, str	eet, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,
he Hospit	within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination at and manner stated.		estigation, in my of	oinion, death occurr	ed at the time,	date and p	place, and due to	the cause(s)
Tot	To t	Σ	29b. Signature and title of certifier  MD  MD		29c. License 4 28	11		Sed. Date	signed (Month,	Day, Year)
			30. Name and address of per or who completed cause of death (Item 23a)  RA Busyne 555 Cyn www.	1	Print)	FASTON	mo	216	"	
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 3 2006  32. Registrar's Signature	A.	med .					

DHMH 17 Rev 1/2001

ORIGINAL

			For State of Maryland / Departing State of Maryland / Departing Certification	ment of Health and M <i>icate of Death</i>	lental Hygien Reg. N	6.000	25882
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month D	av Year	Time of Death
	/Medic	al .	LOIS JEAN SMITH GOOD  4a. Facility Name (If not institution, give street and number)  4b.	, City, Town, or Location of Death	AUG. 2	2006 6 c. County of Deeth	:10 A M
	Examin	ier	13306 OLD WYE MILLS ROAD	WYE MILLS		TALBOT	
	Funeral Director		431–56–0733 1□M 2ĀF 95 Yrs. M	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Dey, Year MAY 17, 1	r)   Country)	(State or Foreign
1	and M		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location	on		10d. I	Inside City Limits
	-f show	tor	MD TALBOT WYE MILLS	5			T ☐ Yes 2 📉 No
1	3e or 28e	al Director	10e. Street and Number 13306 OLD WYE MILLS ROAD	Of. Zip Code 21679	10g. C	itizen of What Country?	
2	s 1 and 2 should be lied within 72 hours after death with the maryland 1 Health and Mental Hygiene. 14 Health and Mental Hygiene. 15 Hear 27 is marked other than "naturel; or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at	by Funeral	1 News Married 2 Married 1 Ves 2 No.	Decedent of Hispanic Origin? (Sps. specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American II Black, White, etc. Specify: WH	
	z nou	ted b	15 Decedent's Education 16a Decedent	's Usual Occupation	16b.	Kind of Business/Industr	
7	Men	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	of work done during most of work NOT use retired)	1	a mpricim	37
V .	Hygien ther ti	e Co	12 4 HUMAN  17. Father's Name (First, Middle, Last)	RESOURCES  18. Mother's Name	e (First, Middle, Maide	S. TREASUR	. <u>Y</u>
<u> </u>	ould be filed Mental Hygi arked other atic event, I	To Be	TILTON GEORGE SMITH	LEONA	M. SMITH		
	z should and Men is marke			ddress (Street and Number or Run			
֓֞֞֜֞֜֞֜֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֜֜֓֓֡֓֓֓֡֓֜֡֓֜֡֓֡֡֡֡֝֡֡֡֡֡֝֡֡֡֡֡֡֡֝֜֡֡֡֡֝֜֝֡֡֡֡֜֝֡֡֡֡֡֝֡֡֝	of Health Item 27 i		20a Method of Disposition 20b. Place of Disposition	OLD WYE MILLS RO		Location - City or Town,	
	permit. Pages Department of the important: If its ony injury or of once.		1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  CENTER	CREMATION 8-3-	4	VENSVILLE,	
ם מ	Depar Impor eny in		Chi M. Hole FELI 408	Ame and Address of Facility LOWS, HELFENBEIN S. LIBERTY ST.,	CENTREVIL	LE, MD 2161	7
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications lifal caused the death. Do not enter it shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)  a. Archivery December 1.  Due to (or as a consequence of):		or respiratory arrest,	Inte	proximate erval Between set and Death
00,00	cate be executed physician and the burial-transit	dical Examiner	Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
0	ng phy as th		IF FEMALE:				
.O. BOX	To the Hospital or Attending Physician: The law requires that the death certil within 24 hours after detect. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3 Ect	topic pregnancy her (specify)		23d. Date of delivery Month Day	y Year
cords, r	uires that signed b id be deta		Part II. Other significant conditions contributing to death but not resulting in the under Renal insufficiency	rlying cause given in Part I.		use contribute to the ca	ause of death?
necol	The law require has been bage 2 shou	Completed	My Pophyris		24a. Was an autopsy performed?	24b. Were autopsy prior to comple death?	ation of cause of
V 150	clan: ertifica ector, p	Be C	25. Was case referred to medical examiner?		h (Check only one)		
5	Physic this c al dire	٩	1 ☐ Yes 20 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient  27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA Other: 4 Nursing Ho	ome 5 K Residence		
5	th. : After funer	tion	1 Natural 5 Pending (Month, Day Yeer) Injury	28c. Injury at Work?  M 1 □ Yes 2 □ No	200. 00001100 1107 111	,ai,y oodaiio	
DIVISION	after dea after dea Director d in by the	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	281. Location (Street and City or Town, Sta	and Number or Rural Ro ite)	oute Number,
:	e Hospita 24 hours e Funeral letely filler	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death oc 2 Madical Examinar: On the basis of examination and/or investigated.	curred at the time, date and place, tigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated and place, and due to the	d. cause(s)
:	vithir To th comp	M	29b. Signature and title of certifier	29c. License number		Date signed (Month, Dey	, Year)
			1////	\$ 63747	81	12/06	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print JEFF7 L. UVF NO 2540 Co Trufte /	10 10- Ane ville no	21617		
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	- )	/		
	Regist	rar	AUG 3 2000 Glove &	els.			

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Ma	ryland / Dep		f Health and		giene	06 2	588
		1. Decedent's Name (First, Middle, Las	(t)				2. Date of Dea Month		3. Tim	e of Death
Physic /Med / Exam	ical	Margaret Esther C	arigliano e street and number)	<del>, , -</del>	4b. City, Tow	n, or Location of Dea	08		6 03	10 M
Funera Directo		5. Social Security Number 6. S	<u>al Medicar</u> ex □M 2*EF 9.	(In yrs. last birthda 4 Yrs.	y) If Under 1 Ye Months Da		s. 8. Date of Birth (Month, Day January		9. Birthplace (Sta Country) New York	ite or Foreig
faryland state	ŏ	Usual Residence of Decedent  10a. State 10b. County  Delaware Sussex		10c. City, Town or Delmar	Location					e City Limits
ith the N or 28a-	Director	Delaware Sussex  10e. Street and Number		Dermar	10f. Zip Cod		<del>-</del>	10g. Citizen of Wh	nat Country?	
ath w	ra ra	101 E. Delaware A			19940			USA		
urs after de al', or items Examiner m	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		If Yes, specify C	of Hispanic Origin? ( Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- irto Rican, etc.)	14. Race Black Specify:	- American India , White, etc. White	n,
Dattilliore, IMarylatin Z.I.Z.13-0030 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at mone.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+	(Given life		ne during most of w tired)	orking	16b. Kind of Bus Bell Tel	iness/Industry	o.
raffor L	To Be Co	17. Father's Name (First, Middle, Last) Edward Agor		Tere	phone Ope	18. Mother's Na	ame (First, Middle,  McKinney	Maiden Surname	)	
Mar y arro d 2 should be fill th and Mental Hy 17 le marked oth traumatic event		19a. Informant's Name/Relationship (Leonard J. Garigli				eet and Number or F				
<b>SARITMOTC</b> , oermit. Pages 1 en Department of Heel Mportant: If Item 2 my injury or other page.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specific	Removal from State	20b. Place of Dis	position (Name or rematory or other	place)	Date	20c. Location - C	ity or Town, State	
Departition of the policy of t		21 Signature of Funeral Service Licen		FSP		y Hill Rd.			1-n-2 210	204
Physiciar /Medica		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused to one cause on each line aASP(R)	he death. Do not e	nter the mode of	dying, such as cardi			Approxi	
xecuted and letransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	· DEMY	CONSEQUENCE UT).	$\checkmark$					
oof ou, ifficate be executed g physicien and as the burial-translt	ca		Due to (or as a	consequence of):						
Physician: The law requires that the death certificate be executed tribs certificate hes been signed by the attending physicien and rail director, page 2 should be deteched for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome or 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	□Ectopic pregna □ Other (specify			23d. Date Mont		Year
w requires that the tent of the signed by should be determined.	Ď	Part II. Other significant conditions c	ontributing to death but	not resulting in the	underlying cause	given in Part I.	100	bacco use contrib		of death?
OI VIIdI necol us, Physician: The law requires t this certificete hes been signe rai director, page 2 should be o	Completed				. 12.0			sy pri	ere autopsy findir or to completion ath?	ngs available of cause of
ician: The certificete ector, pag	Be	25. Was case referred to medical examiner?	/				eath Check only or	7e)		
To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	tlon: To	1 ☐ Yes 2 ☑ No  27. Mannef of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: Inpatient 28a. Date of Injury (Month, Day	28b. Time	of 28c. [	Other: 4 Nursing	Home 5 ☐ Resid 28d. Describe h	ence 6 Other ow injury occurred		
or Attending effer death. I Director: After din by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, offi	се	28f. Location (S City or Tow	itreet and Number n, State)	or Rural Route I	Vumber,
To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Medical C	29a Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of tiner: On the basis of e and manner state	examination and/or	tth scoursed at the investigation, in m	a time, date and plan ny opinion, death occ	te, and due to the courred at the time, o	dues(e) and Tandate and place, an	nor as stated d due to the cau	se(s)
To the To the Complete	₩	29b. Signature and title of certifier	MD			ense number		8 16	Month, Day, Yea	ar)
10 mg		30. Name and address of person who NEMAL DOSK!				04 B SI	MSBUR	7 mp 2	1804.	
S Regis	ate trar	31. Date filed (Month, Day, Year) AUG 0 2 20	32 Registrar	's Signature	barks			*		

DHMH 17 Rev 1/2001

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Cariglians Margaux

06-05631 Anthony L. Grimm UNK UNK

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

1011 2509.

	1- For State Certificate of Death Reg. No.												
Physicia		Month Day Year										3. Time of	
ledical Exami	ner	ANTHONY L. G	RIMM						August		<b>1</b> 6	0/31	hrs
		4a. Facility Name (if not institut Colby Road and Lew	. •	mber)	41	o. City, Town, or Easton	Location or	f Death			4c. County o Talbot	f De <b>a</b> th	
Puneral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Yea	r If Under	r 24Hrs.	8. Date o	f Birth (N	IM/DD/YYYY)	9. Birthplace (Sta	ate or
Director		205-68-7533	1 <b>X</b> M 2 F	18	Yrs	Months Day	s Hours	Min	JAN	26,	1988	Foreign Country) <b>P</b>	A
	[	Usual Residence of Decedent		140- 07-	T and anni-							10d Insid	e City Limits
y any		10a. State 10b. Count			Town or Locatio								s 2 X No
daryland 28a-f show 1 at once.	5	MD CA	ROLINE	G.	REENSBO								5 2 <b>X</b> 110
1817	Director	10e. Street and Number				10f. Zip Code				10g. (	Citizen of Wh	at Country?	
th the Maryland 23a or 28a-f sho notified at once.		13060 LOGAN	LANE			216	39				· U	SA	
15-0036 fited within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status				Decedent of Hi s, specify Cuba					14. Race White	<ul> <li>American Indian, etc.</li> </ul>	Black,
or if	큔		1 Yes	2 <b>X</b> No	1□	Van 2 🗔 Na	one cifu:				Specify:		
s afte.	<u>a</u>	3 Widowed 4 D  15. Decedent's Education (Sp	or Dates:		16a. Decedent	Yes 2 X No		and of wo	rk done	16		WHITE siness/Industry	
hours af	te	Elementary/Secondary (0-12		, , , , , , , , , , , , , , , , , , , ,		st of working life				10	b. rand of ba	Sincoon nadou y	
5-0036 fled within 72 Hygiene. I other than "the Medical I	ompleted		.) Jonege (1	40101)	COTT	TINENU				Ì	COLL	FCF	
swift con the control of the control	ĕ	12. Father's Name (First, Middl	le, Last)		21	UDENT	18.Mother	s Name (F	irst, Mide	dle, Maid	en Surname)		
21215-0036 uld be filed within 7 Memal Hygiene. marked other than	Be C	BARRY R. GRI					DE	BORAI	I I	WAT!	SON		
212 Jid bo Ment mark		19a. Informant's Name/Relation			19b. Mailing	Address (Stre						n, State, Zip Code)	
MD d 2 shoulth and n 27 is aumatic	-	BARRY R. GRIM	M. JR./FAT	HER	1306	O LOGAN	LANE	. GRI	ENSI	ORO.	MD 2	1639	1,1
and and fealth item	1	20a. Method of Disposition		20b. P	lace of Disposit	ion (Name of ce		-	Date			City or Town, Stat	е
Baltimore, cornit Pages I an Department of Her Iniuportant. If ite mijury or other it		1 Burial 2 X Cremati	on 3 Removal fr	om State	rematory or other	, ,		on (	. / 0 / /	,,,,			100
timen rtant	-	4 Donation 5 Other 21. Signature of Funeral Service		CH	ESAPEAK	E CREMA' me and Addres			3/3/2	2006	STEV	ENSVILLE,	<u>, MD</u>
Baltimore, MD 21215-003 parmit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other I injury or other traumatic event, the Medinjury or other traumatic events.		21, Signature of Fulleral Service	Licensee .		FE	LLOWS,	HELFE	NBEIL	1 & I	IEWN/	AM FUN	ERAL HOMI	E PA
Physician	-	23a, Part I, Enter the disease,	or complications that c	aused h.	Do not enter the	O S HA	RRTSO	N ST ardiac or r	EAS' espirator	y arrest.	MD 21 shock, or hea	601 art Approxir	nate Interval
/Medical		failure. List only one caus	se on each line.			, ,						Between	n Onset and Death
xaminer		Immediate Cause (Final diseasor condition resulting in death)		es consequence of	F\-							_	
- The state of the			b	r corrocquerioe or	7.								
	힐	Sequentially list conditions, if any, leading to immediate		consequence of	F):								
	튑	cause Enter Underlying Caus (Disease or injury that initiated	C										
tod I Insit	Examiner	events resulting in death) Las	t Due to (or as a	consequence of	1):							1	
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18760, rtificate be on ing physician as the burial	ΝĒ	IF FEMALE:	the second second	outcome of pregr							23d. Date of	•	
as as as	ian/	23b. Was decedent pregnant in past 12 months?	Descri	oirth nant at time of dea	2 Fet		Ectopic	pregnan	су		Month	Day	Year
Records, P.O. Box 61 The law requires that the death cort cate has been signed by the attendin page 2 should be detached for use a	Physicia	1 Yes 2 No 9 L	Jnknown 9 Unkn		ath 5 Oth	er (Specify)							
D. B. trthc do by the ached f	된	Part II. Other significant con-			esulting in the ur	nderlying cause	given in Pa	ırt I.	23e. I	Did tobac	co use contri	bute to the cause	of death?
P.O.	Š	•	•			, ,			1	Yes 2	2 <b>✓</b> No 3	Probably 4	Unknown
rds, F requires s been sign	Completed								24a. \	Vas an	24b. V	Vere autopsy findir	ngs available
OFC dw fc ias be 2 sho	g									autopsy performe		rior to completion leath?	of cause of
Division of Vital Records, rad or Attending Physician: The law requir is after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should be	no.								1 🗸			✓ Yes 2	No No
tal Re(ian: The	Be	25. Was case referred to medi examiner?			-	26.Plac	e of Death	(Check or	nly one)				_
Vit hysical this call dire	TOE	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		Other <sub>4</sub>		Home 5			Other: Scene	
of ang P. After unera		27 Manner of Death	28a. Date	of Injury n, Day,Year) ):	28b. Time of in	jury 28c. Inj	ury at Work	. In			injury occurr	<sub>ed</sub> I and auto ove	erturned
ion tondi eath.	atio		ending FOUNL Aug 1, 2		FOUND: 0731 hrs	1	Yes 2	No					
ViS a. At firer d Sirect in by	iţi			ce of Injury - At ho	ome, farm, stree	t, factory, office	building, et	c. 2		ion (Stre wn, State		er or Rural Route I	Number, City
Di Malo Murs a Murs a Murs a	Certification:		etermined (Specify)	Road				c				Rd, Easton, I	MD
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this centifi completely filled in by the funeral director.		(Ondok of it)	Physician: To the be										
Fo the vithin omple	Medical	2 🖳	xaminer: On the basis and manner:		nu/or investigati			curred at	u ie time,				
F->F-0	ž	29b. Signature and title of cert					se number					ed (Month, Day, Ye	ear)
		my a	, mid			0.0	.M.E.			A	ugust 1, 2	2006	
30. Name and address of person who completed cause of death (Item 23a)							-						
			tant Medical Exa	miner 111	Penn Stree	t, Baltimore	, MD 212	201					
	tate	31. Date filed (Month, AUG	ar)n 3 200 6 22. R	egis ar's Signatu	ıre	Coart o							<del></del> _
Regis	7	no a	A TAMO	13 A 15 A 15 A 15 A 15 A 15 A 15 A 15 A	- 1 Th	COMMON AND AND							

December 1 Name (First, Models, Last)  Physician (Models)  Arthur Barkley Greenwell  4s. Facility Name (First, Models, Last)  Arthur Barkley Greenwell  4s. Facility Name (First, Models, Last)  Arthur Barkley Greenwell  4s. Facility Name (First, Models, Que street and running)  Function	
Physician   December   Name (Frst, Middle, Last)   Arthur Barkley Greenwell   A. Facility Name (Incor institution, give streat and number)   A. City, Town, or Location of Death   A. County of Death	5885
Medical Examiner   4a. Facility Name (fired institution, give sizes and number)   4b. City, Town, or Location of Death   4c. Coury of Death   Cecil   716 North Saint Augustine Road   Chesapeake City   Chesape	ne of Death
## As Facility Name (if not institution, give street and number)    The North Saint Augustine Road   Chesapeake City   C	200. M
Funeral Director  Fineral Dire	
Director  Direct	
10a State   10b County   10c City, Town or Location   10d Institute   10d In	
Kathleen M. Stover/Daughter   716 N. St. Augustine Rd., Chesapeake City, M.	de City Limits
Kathleen M. Stover/Daughter   716 N. St. Augustine Rd., Chesapeake City, M.	
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Kathleen M. Stover/Daughter   716 N. St. Augustine Rd., Chesapeake City, M.	
Kathleen M. Stover/Daughter   716 N. St. Augustine Rd., Chesapeake City, M.	
Physician /Medical Examiner  Sequentially list conditions, and sequence of the	0.21015
Physician /Medical Examiner  Sequentially list conditions, and sequence of the	
Physician /Medical Examiner  Sequentially list conditions, and sequence of the	
Physician /Medical Examiner  Sequentially list conditions, and sequence of the	
Physician /Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and yearting to imm and any least on the complete of th	21921
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease	umate
resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, and beautiful to the conditions, and the conditions are considered to the conditions and the conditions are considered to the conditions are conditions.  Due to (or as a consequence of):	il Between and Death
Sequentially list conditions, and such as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Due to for as a consequence of:  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to for as a consequence of:  C. Due to (or as a consequence of):	
IF FEMALE: 23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Ves   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Mont	
Second   S	
23d. Date of delivery month Day  23d. Date of delivery month Day	
Pregnant at time of death   S   Other (specify)   S   Other (spe	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the conditions of the cause of t	
1   Yes 2   No 3   Probably  24a. Was an autopsy fin prior to completic death?  1   Yes 2   No 3   Probably  24b. Were autopsy fin prior to completic death?  1   Yes 2   No 1   Probably  25. Was case referred to medical  26. Place of Death (Check only one)	e of death?
24a. Was an autopsy fin prior to completic death?  1	
performed? death?  1 Yes 2 1 No 1 Yes 2 1 No 1 Yes 2 1 No 1 Yes 2 1 No 1 No 2 No 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one)	ings available
25. Was case referred to medical 26. Place of Death (Check only one)	
a saminer?	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify)	
= 32 = 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
2 Accident investigation M 1 Yes 2 No  2 Steel Steel Suicide 6 Could not be determined and suicide 1 Street and Number or Rural Route	Number
building, etc. (Specify)  City or Town, State)	TYUMOUT,
29a. Certifier   29a. C	Jse(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	ar)
MD D0056449 8/10/06	
6-1 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 lovia Simonson MD 111 West High St. Suite 300 Elkton MD 2192	
State Registrar AUG 1 6 2006 32. Pgistrar's Signal State AUG 1 6 2006	

			For State Registrar, 1 #0011 D			Co	artmen <i>rtificat</i>				ental Hyç	giene. Reg. No.	2006	25	886	
	Physici	20	1. Decedent's Name (First, Middle, Las.	er ini G	858 8/16			-			2. Date of Dea Month		Year		of Death	
	/Medic		CHRISTOPHER		HOGO	GARD	45 0:5:	T	. I sestion	of Dooth	JULY 2		006 Year	2:00	Рм	
	Examin	er	4a. Fecility Name (If not institution, give 7715 WINGATE DRIV		mo <del>u</del> r)		GLEN		r Location o LE	oi Deatii				EORGE'	S	
	Funeral		Social Security Number 6. S	x	7. Age (In yrs	. last birthday)		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day		9. Bir <i>C</i> c	thplace (State	or Foreign	
	Director		578-84-9620 13 Usual Residence of Decedent	ØM 2□F	39	Yrs.	I VIOINI I O	50,0	1,02.0		DEC. 1	<del>5</del> 196		HINGTO	N,DC	
	land ow		10a. State 10b. County		10c. C	City, Town or Lo	ocation				0	0		10d. Inside	City Limits	
	a-f eh	ctor	MD PRINCE (	EORGE'	s	GLENN	DALE							1 <b>½</b> Y€	s 2 No	
	or 28	Director	10e. Street and Number				10f. Zip					10g. Citize	en of What Co Δ	ountry?		
	sath w	eral	7715 WINGATE DRIV		edent Ever in	118 12		769	lienanie Ori	igin? (Spe	cify Yes or No-		4. Race - Ame	encan Indian		
36	72 hours after death with the Maryland natural; or Items 23a or 28s-f ehow Jisal Examinat must be notified at	by Funeral	11. Marital Status  1 XXever Married 2 Married 3 Widowed	Armed For 1 Yes If Yes, Gir Year or D	rces? 2 🕅 No	0.3.	If Yes, spe	cify Cuba	Specify:	n, Puerto	K, Puerto Rican, etc.)  Black, White, etc.  Specify: BLACK					
21215-0036	72 hour "natural"	ed b	15. Decedent's Ed	ucation	rates.	16a. Dece	dent's Usu	al Occup	ation		)	16b. Kind	d of Business	/Industry		
215	c * 4	Completed	(Specify only highest grad	College (	1-4or 5+)	(Give	kind of wo DO NOT u	rk done i se retired	during mos i)	t of worki	ng					
2	filed within Hygiene. other then		az E w labla a C a Afidd la la d	4+		IT S	PECIA	LIST			GOVERNMENT  ar's Name (First, Middle, Maiden Sumame)					
Maryland	0 0 0	To Be	17. Father's Name (First, Middle, Last) GEORGE HOGGARD								NN SINC					
ary	s 1 and 2 should be Health and Menta tem 27 te marked other traumatic ex	۲	19a. Informant's Name/Relationship (7		· · · · ·		•				l Route Numbe					
Σ,	1 and 2 Health tem 27 l		TAMMY BENNETT/SIS	TER	laat				AVENU		302 CAE				20743	
Baltimore,	80		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		State	Place of Dispo	matory or c	other plac			ate		ation - City or			
Hir	permit. Pag Department Importent: I any Injury o		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen:		RI	VERDALI 2					-			MARYLAI AT. HOMI		
Ba	Pem Imp		21. Signature of 5uneral Service Licensee  22. Name and Address of Facility J  7474 LANDOVER ROAD											2078		
	Physician /Medical Examiner	Iner	23a. Part 1. Enter the disease of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to	each line. EPATIC (or as a conse JPOSIS (or as a conse	INSUFF: equence of): SARCOMA	ICIEN		g, such as	oaldiac c	Tospiratory at			Approxim Interval B Onset an	letween	
Box 68760,	The law requires that the death certificate be executed the best been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	resulting in death) Last	c.  Due to  d23c. If yes, ou	IDS (or as a conse	nancy						23	3d. Date of de	Blivery		
P.O. Bo	it the death by the atter tached for	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ointh 2 ☐ Fe nant at time of lown		⊒Ectopic p ⊒ Other (sp		<i>'</i>				Month	Day	Year	
	w requires tha been signed I should be det	þ	Part II. Other significent conditions or	ntributing to d	eath but not re	esulting in the u	inderlying (	cause giv	en in Part I	l. 	23e. Did to			o the cause o		
of Vital Records,		Complet	24a. Was autog perfo									24b. Were a prior to death?	utopsy finding completion of s 2 No	s available cause of		
Vita	Physiclan: rthis certificantal director,	25. Was case referred to medical examiner?  1 🖸 Yes 2 No														
	Phys rahdi													ecify)		
ion	1   Natural     1   Natural								k? Yes 2□	No		, ,				
Division	P in in in	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place	of Injury - At ing, etc. (Spe	home, farm, st	reet, factor	y, office			28f. Location (5 City or Tox	Street and vn, State)	Number or F	iural Route Nu	umber,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	iner: On the b	e best of my k pasis of exami oner stated.	nowledge, deal nation and/or in	h occurred evestigation	at the tir	ne, date ar ppinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	s stated. e to the cause	e(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	MA	20		29	100	e number	2	1=			Day, Year,		
	(	) Dea W. MOB 33 57/25/2006							·							
1	- 60/	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  THEO HODGE M.D. 650 PENNSYLVANIA AVENUE S.E. # 220 WASHINGTON, DC 20003														
79	Sta	ate	31. Date filed (Month, Day, Year)	349. F	Registrar's Sig	nature										
	Registi	rar	1111 2 8 200	The state of		K Son	1									

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of F	lealth and M Death		jiene 🤌 (	306	25887
	Physici /Medic		1. Decedent's Name <i>(First, Middle, L</i> as <b>Tauqir</b>	Wilaya	t	Husai	n	2. Date of Dea Month 7 – 28	3-06	Yeer	3. Time of Death 7:15p M
	Examin Funeral Director		4a. Facility Name (If not institution, give 4821 Flanders  5. Social Security Number 6. Sec. 211-68-7015	Ave	ast birthday) Yrs.	4b. City, Town, or Kensi If Under 1 Year Months Days	ngton  If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Dea Montgo Birth Day, Year, 8 In		lace (State or Foreign try)
		tor	Usual Residence of Decedent  10a. State 10b. County		, Town or Lo	ocation ington					0d. Inside City Limits 1X Yes 2 ☐ No
	3a or 28a	Il Director	10e. Street and Number 4821 Flander	s Ave		10f. Zip Code	895	1	10g. Citizen o	f What Coun	try?
350	within 72 hours after death with the Maryland ene. then "naturel", or Itams 23a or 28a-f ehow the Madical Executar transit te medified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba  1 Yes 2 1	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	ВІ	ace - Americ lack, White, e cify: Asia	etc.
9500-6121	within 72 hou ene. then "natura ne Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation	(Give	dent's Usual Occup kind of work done of DO NOT use retired emaker	ation during most of work I)	ing	16b. Kind of		lustry
Maryland 2	a Hygi Tother vent,	To Be Co	17. Father's Name (First, Middle, Last) Anwaruddin	Syed			18. Mother's Nam Saeeda	e (First, Middle, Begun		ame)	
	and 2 shoulaith and Mariana Marite mail		19a. Informant's Name/Relationship (7 Noni Byrnes –			ng Address (Street Flande					
saltimore,	. Pages 1 and 2 should b iment of Health and Ment: tant: If Item 27 is marked lury or other treumatic e		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State Ma	emetery, crer rylan	osition (Name of matory or other place d Nation	nal 7-2			1, Ma	aryland
Rail	permit. Page Department of Important: If any Injury or		21. Signature of Tuneral Service Ligen:	Males	_ 4	11Kenne	dy St,N	.W.,Was	shingt		
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٥٥,	cate be executed bhysicien and burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
O. Box 68/60,	death certifi e attending ed for use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No 9 □ Unknown	d	death 3	□Ectopic pregnancy □ Other (specify)				Date of delive	ry Day Year
7	requires that the de wen signed by the a hould be detached f	þ	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.		bacco use co es 2. <b>∏</b> No		e cause of death?
of Vital Records,	The law ste hes b page 2 s	Completed						24a. Was a autops perfor	sy med?	o. Were autor prior to con death? 1  Yes	osy findings available inpletion of cause of
<u> </u>	Physiclan: rthis certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	h <i>(Check only or</i> me 5⊠Resid		ther (Specify	·
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Division	声舞는	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specifi	<i>'</i> )			28f. Location (S City or Tow	n, State)		
	To the Hospitel within 24 hours a for the Funeral completely filled	Medical	29a. Certifier 1	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	h occurred at the tin westigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, o	ause(s) and r late and place	manner as sta e, and due to	ated. the cause(s)
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2	(2)		30. Name and address of person who calph V. Bocc	ia,M.D. 64	20 Rc	Print) ockledge	Dr,Bet	hesda,	Maryla	and :	20817
Sac.	Sta Registi		31. Date filed (Month, Day, Year)  AUG 0 1 2006	32. Registrar's Signa	bert	No.					

			1 - State Amend item#25,2	State o 7,28a-f,p	f Marylander/E,g859	d / Depa ,9/28/06	rtment of H	ealth and Death	Mental Hyg	giene	116	25222
			Decedent's Name (First, Middle, Last						2. Date of Dea	ath	Vana	3. Time of Death
	Physicia /Medic		Verleece D.	Hill					July 2	4, 2006	Year	5:00p M
1	Examin	_	4a. Facility Name (If not institution, give		mber)		4b. City, Town, or	Location of Deat	h	4c. County	of Death	
			Casey House				Rockvi			Mont		-
	Funeral		5. Social Security Number 6. S	ex □M 2√x□F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year)	Cour	
	Director	. }	578-54-0882 Usual Residence of Decedent		67				Dec. 14	, 1938	wası	hington,D.C.
	/land	Ì	10a. State 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	Mar.	to	Maryland Montgome	ery	G	ermanto	own					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			-	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	23a		12801 Locbury Ci	y -			20874			United		
	er de	Funeral	11. Marital Status	Armed Fo		S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	specify Yes or No- to Rican, etc.)		e - Americ k, White,	can Indian, etc.
36	F, or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🚰 Divorced	1 ☐ Yes If Yes, Gin Year or D	ve T	1	☐Yes 2万No	Specify:		Specify	: Blac	ck .
Ş	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at	ted	15. Decedent's Ed	ducation		16a. Deced	ent's Usual Occupa	ition		16b. Kind of Bu	siness/In	dustry
215	hin 7.	Completed	(Specify only highest gra	College (	1-4or 5+)	life. E	kind of work done of OO NOT use retired,	iuring most of wo	nking			
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Ind	d oth	Be	17. Father's Name (First, Middle, Last)						me (First, Middle,			
yla	ould I Men narke	٤	Roland Maurice H:		•	105 14-15-	- 4 - 1 - 1		ce Le'Po			0-4-1
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e,	1 and Heelt tam 2		20a. Method of Disposition	-	20b. P	lace of Dispos	sition (Name of		Date	20c. Location -		own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant, the Medical Examinat must be notified at one.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)	-	State	-	iatory`or other place lemorial		29,2006	Suitla	nd M	d.
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o	caused the death	n. Do not ente	er the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
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Em	/Medical Examiner		resulting in death)		(or as a consequ		_		1	UNER		
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	nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		drapleg:	·		11 ~	N PROVED BY M			
	axecur and al-trai	Examiner	that initiated events resulting in death) Last	C	(or as a consequ			CERTIFIC ON	Mr.			
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dlcall		_ d				CENT				
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Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy				e of delive	
O.E.	e dea the at ned fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		nant at time of de		Other (specify)			Moi	าเท	Day Year
P. 0.	that the de ned by the a detached t	Ph	Part II. Other significant conditions of	ontributing to d	eath hut not resi	ulting in the ur	iderlying cause give	on in Part I	23e Did to	phacco use contr	ibute to the	he cause of death?
ds,	8 5 g	d by	, u.,									oably 4 Unknown
20	w requir been si should	Completed			•				24a. Was	an 24h V	Nore auto	ppsy findings available
Re	e la hes je 2	d Li							autop perto	rmed?	rior to co leath?	mpletion of cause of
tal		0	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath <i>Check</i> only o	-	□Yes	2 No
<u>&gt;</u>	Physician: this certific ral director,	To B	examiner? 1 X Yes <del>2 No</del>	Hospital: 1	Inpatient 2	ER/Outpatien	t 3□ DOA Othe		Home 5 ☐ Resid		er (Specif	ý)
0	ng Ph tter th treral		27. Manner of Death  → Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe h Subject wa	now injury occurr		in car
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Division of Vital Records,	afte date d	Certification:	4 Homicide determined	build	ing, etc. (Specif)	ome, farm, stre v)	eet, factory, office		City or Tov	Street and Number vn. State) Penr	er or Rura ISYIVA	al Route Number, inia Avenue at
	lospital hours a uneral f		29a. Certifier 12 Certifying Ph	Koadw		wledge death	occurred at the tim	e date and place				Heights, MD
	a Hospital 24 hours a a Funeral ( letely filled	edical		niner: On the b			estigation, in my op					
	To the Hospital or extending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier				29c. License	number		29d. Date signed	i (Month,	Day, Year)
			Cynthia m. J.	Velleame	, DO		H009	58032		July 2	26, 2	.006
1	[ (10)		30. Name and address of person who	completed caus	se of death (Item			,	3	4		
1	17		CYNTHA M. WILLIAMS, 31. Date filed (Month, Day, Year)	D.O. Mon	tgomery h	tospice	6001 Mun	caster Mu	URd Koc	Kuille, N	D 2	085 Z
,	Sta Registi		JUL 3 1 200	16	Registrar's Signa	loc	le					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 23 1540 07 06 Mattie Hyson

4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday). 84 Yrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 √ F Months 13 Virginia Director 579-26-5739 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 28a-f show ?7 is marked other than "naturel", or Iteme 23s or 28s-f ebov treumatic event, the Modical Examiner must be notified at 1**½** Yes 2 ☐ No Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if them 27 is marked other than "---- eny injury or other treumarin-USA 20012 44 Van Buren St N.W Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th. Dietian Andrews Air Force Base 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walter Jefferson Rosa Ann Height 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20879 19a. Informant's Name/Relationship (Type, Print) 18715 N. Frederick Ave. #406 Gaithersburg, MD. Donna HYson/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 108-04-06 Silver Spring, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Functal Home 21. Signature of Funeral Service Licenses 4217 9th. St. N.W. Washington, D.C. 200ll mai 23a. Part Entel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Oue to (or as a consequence of) Examiner nuing physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy the atter in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate has 2 No 1 Yes After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ 1No 1/ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident the within 24 hours after deatl To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a, Certifier 🕼 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier MAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grove Dr. Rockville, Nd. ILMONO 31. Date filed (Month, Day Year) 2. Registrar's Signature State 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 30, 2006 Physician SAMUEL MORRISON HASTINGS 6:45A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY CASEY HOUSE ROCKVILLE 8. Date of Birth (Month, Day, MARCH 1, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1¥ M 2□ F Months Days Hours Min DELAWARE 222-07-9048 81 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County octant: и nem z/ te marked other than "natural", or items 23a or 28s-f ehow r injury or other traumatic event, the Mucical Examiner must be notified at se. 1 ☐ Yes 2 No MARYLAND. MONTGOMERY SANDY SPRING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1733 HICKORY KNOLL ROAD 20860 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No If Yes, Give WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT AERONAUTICAL ENGINEER 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be finand Mental Fiermarked of RAYMOND D. HASTINGS AMELIA CRANMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 ie ir any injury or other traum once. MARION E. HASTINGS - WIFE 1733 HICKORY KNOLL ROAD, SANDY SPRING MD 20860 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ROCKY GAP MD STATE 1 \ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY 8/3/2006 FLINTSTONE, MD 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Service Licensee Muselin 11800 NEW HAMPSHIRE AVE; SILVER SPRING MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PROSTATE CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury attending physician end for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 🕅 No 1 Tyes To the Hospitel or Attending Physician: within 24 hours alter death. To the Funeral Director: Atter this namition : After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Cynthia M. Milliams, O.O. HOO 580 3Z 7/31/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Null Rd Rockville MD 20852 CYNTHA M. WILLIAMS, D.O. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2006

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			For State Registrar	State	of Maryland		artment			and M		giene Reg. No.	0.6	25891
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*.	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. I		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)		place (State or Foreign
w.i.	Director		578-56-5470	1 M 2 LALF	64	Yrs.					March 28	3, 1942		yland
	and		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City	/, Town or Lo	cation							10d. Inside City Limits
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and	d be f	o Be	James Beatt							izabe		pley	,	
Maryland	shoul nd Me mark	မ	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address	(Street a				er, City or Town	State, Zij	o Code)
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ore,	of He of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Demoval from	20b. P	lace of Dispo emetery, crer	sition (Nam natory or of	ne of ther place	θ)	С	ate	20c. Location	· City or T	own, State
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Il Records,	The law ete has b pege 2 s	Completed					-				24a. Was autor perfo 1 🗆 Yes	rmed?	death?	opsy findings available ompletion of cause of
of Vital	Physicien: Th this certificete ral director, peg	Be	25. Was case referred to medic examiner?	Hospital:				Othe	or.		Check only o			
to		To.	1 Yes 2 No 27. Manner of Death	11	Inpatient 2  e of Injury	ER/Outpatier 28b. Time o		JA .	4 🗀 190			dence 6 Ott		<i>fy</i> )
O	Attending Ph r death. sctor: After thiby the funeral	tion	1 ØNatural 5 ☐ Pend	ding (Mo	e of Injury onth, Day Year)	Injury	М	8c. Injury Work	k? Yes 2 ☐					
Division	- 9	Sertification:	3 ☐ Sutcide 6 ☐ Coul	minod 289. Pla	ce of Injury - At ho ding, etc. (Specify	ome, farm, str	reet, factory	r, office			28f. Location (S City or Tox		ber or Rur	al Route Number,
	To the Hospitel c	edical C	29a. Certifier 1 Certify (Check only 2 Medical	ring Physician: To t al Examiner: On the and ma	he best of my kno basis of examina inner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my of	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as s and due t	stated. to the cause(s)
	To the within 2 To the complex	M	29b. Signature and title of certif	ier	-		290	. License	e number			29d. Date signe	ed (Month,	Day, Year)
,			) OILL	26				D5068	86			August 1	0, 200	06
U	JA C		30. Name and address of person		_									
	a Car		Gurdeep Chhabra 31. Date filed (Month, Day, Yea	,	5 Three No Redstrar's Signa		d, Hol	lywoo	d, Mar	yland	20636			
8	Sta Regist			1 1 2006			See al							

			For State Registrar		State of	f Marylar		artment of H <i>rtificate of</i>		id Mental	Hygier Reg. i	- L U	06	25892
	<b>D</b>		Decedent's Name (First	, Middle, La	st)					2. Date of	of Death		Near	3. Time of Death
	Physicia /Medic				all			45 675 7		Augu:		Day 2	006	1510 м
	Examin	er	4a. Facility Name (If not in Harford Me					4b. City, Town, o				46. County Harfo		
	Funeral	-	5. Social Security Number	6. 5	Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24		of Birth			lace (State or Foreign try)
	Director		215-03-662	.5	1 □ M 2 <b>)</b> (2) F	94	Yrs.	Months Days	Tiodis	Nov.	29,	7911	Mary	zland
	land ow		Usual Residence of Deceded 10a. State 10b.	County		10c. Ci	ty, Town or L	ocation					1	0d. Inside City Limits
	Mary a-f eh	tor	MD	Harfo	rd	A	berdee	n						1 X Yes 2 ☐ No
	ith the Marylan or 28a-f ehow	Director	10e. Street and Number			•		10f. Zip Code			10g.	Citizen of \	What Coun	itry?
	72 hours after death with the Maryland natural', or Itema 23a or 28a-f ehow deal Examiner must be notified at	erail	469 Bernic	e Ter		edent Ever in U	10 13	2100°		2 (Specify Ves	or No-	.,	e - Americ	an Indian
"	after death w or items 23s	Funeral	11. Marital Status 1 ☐ Never Married 2	☐ Married	Armed Fo	rces? 2 ⊡kNo	7.3.	Was Decedent of I If Yes, specify Cub		Puerto Rican, etc	)	Blad	ck, White,	
036	ours a	þ	3 ☐ Widowed 4 🙀 D	ivorced	If Yes, Giv Year or D	des:		1 ☐ Yes 2 🗓 No				Specif	AATT	
15-6	"natural",	ete	15. D (Specify onl	ecedent's E y highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most o	f working	16b	. Kind of B	usiness/Ind	dustry
12.	iene. r then "	Completed	Elementary/Secondary 12	(0-12)	College (1	1-4or 5+)	Offi		-,		Ci	vil S	ervi	ce
Ja.	a filed al Hyg l other vent,	3e C	17. Father's Name (First,							Name (First, M			ne)	
ylaı	12 should be filed within h and Mental Hygiene. 7 is marked other then " traumatic event, the May	To Be	George Wil				100 11 11			Jane S		,	C4-4- 7:-	0-41
Z Z	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 is marked other then "naturat", or Itema 23a or 28a-1 ehov other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/A			thter		ng Address <i>(Stree</i> ) Snake Li		urchvil			028	(506)
5	s 1 and 2 of Health item 27 i		20a. Method of Disposition	n		20b.		osition (Name of matory or other pla	100	Date	_	. Location -		wn, State
<u>ii</u>	Page ment c		1 ⊈Burial 2 □ Cred 4 □ Donation 5 □ C			State	vary U	nited Me	th. Cen				ville	, Maryland
⊃ Baltimore, Maryland 21215-0036	permit. Pages. Department of the Important: If Ite eny Injury or of once.		21. Signature of Funeral	Service Lice	nsee Ze 1	lmi.		2. Name and Addr arring-C berdeen,	argo Fu Maryla	neral H	ome,	P.A.		
yv			23a. Part1. Enter the disc	ease, or cor	one cause on s	aused the dea								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		P	ulme	nam	Eml	roleen	Α.				Onset and Death
0	/Medical Examiner		resulting in death)	(	Due to	(or as a conse	quence of):							
S		er	Securitially list condition if any, leading to immedia	ate	b. Due t	(or as a conse	quence of):	0						
	cuted nd ransit	Examiner	Secuentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	1	c.									
60,	ficate be executed physicien and s the burial-transit	al Ex	resulting in death) Last		Due to	(or as a conse	quence of):							
<i>106</i> 68760,	ficate physics the	edicai			<b>d</b> .								1	
N X	sath certii attending for use a	In/M	IF FEMALE: 23b. Was decedent pregr		23c. If yes, ou	tcome of pregn		⊒Ectopic pregnanc	·v				te of delive	*
€. B	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	is?		ant at time of		Other (specify)				Mo	onth	Day Year
به م	es that th gned by be detac	y Ph	Part II. Other significant	conditions	contributing to d	eath but not re	sulting in the	underlying cause g	ven in Part I.	23e.	Did tobace	co use con	tribute to th	ne cause of death?
TARR, ecords,	quires an sign	ed by									1 🗌 Yes	2 □ No	3 ☐ Prob	ably 4 Inknown
F OSO	law re as bea	Completed									Was an autopsy		prior to co	psy findings available mpletion of cause of
<u>a</u>	i: The licate ha									10,			death?	2 □ No
Vital	sician: Th certificate irector, pag	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	medical	Hospital:	Inpatient 2	TER/Outpatie	nt 3□ DOA Ot	her	ing Home 5		e 6 □0th	ner (Snecif	izl
30	Attending Physician: r death. ector: After this certifice by the funeral director,	n; To	27. Manner of Death	3 Danetina		ol Injury th, Day Year)	28b. Time			<del></del>		njury occur		//
Sion	ttendin death. stor: Af / the fur	catic	2 Accident	Pending investigation Could not	on			M 1	Yes 2 No					
Ha	it or Att efter d I Direct d in by	Certification:	4 Homicide	determine	200. Place	of Injury - At I ing, etc. (Spec	nome, larm, s ify)	reet, factory, office			or Town, S		ber or Rura	il Route Number,
	To the Hospitat or Att. within 24 hours efter de To the Funerel Direct completely filled in by t	dical C			miner: On the b	asis of examin		th occurred at the to						
_	To the within 2 To the comple	Med	29b. Signature and title o	f certifier	and man	ner stated.		29c. Licen	se number		29d.	Date signe	ed (Month,	Day, Year)
	->-		> G lu	_chr c		MD		Da	0632	20		8/2	120:	06
	10		30. Name and address of	person who	completed cau	se of death (Ite	m 23a) (Type	Print) G	CORGE (	150	MA	Rus	10	
	Str	ate	31. Date filed (Month, Da	Y1 Ypar)	200632. F	Registrar's Sign	nature L	100	- ( TI	1 M	1)	210	7	
	Regist		ļ	106 4	2000	The state of the s	J	The same						

			For State Registrar	State o		nd / Depa		t of H	lealth a		lental Hygi	-	06	25893
			1. Decedent's Name (First, Middle	, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		LAURA BELLE H	EGDON							AUGUST	1	2006	12:15PM <sup>M</sup>
1	Examin		4a. Fecility Name (If not institution,	give street and nur	nber)				r Location	of Death		4c. Count	ty of Death	
			WILLIAM HILL 1  5. Social Security Number		7. Age (In yrs.	last hirthday)		EAST 1 Year	ON If Under	24 Hrs.	8. Date of Birth		TALI 9. Birthol	
	Funeral Director		218-22-1229	1 □ M 2 <b>X</b> F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, OCT 29,			lace (State or Foreign try)
	ס		Usual Residence of Decedent											0d. Inside City Limits
	show	5	10a. State 10b. County		100. CI	ty, Town or Lo							''	1 XYes 2 □ No
	the M	ecto	MD TALI  10e. Street and Number	BOT		EA	STON 10f. Zip	Code			10	Og. Citizen of	What Coun	trv?
	3a or	Funeral Director	2 ST. JAMES CO	OURT					601			-	US	
	death	nera	11. Marital Status		ident Ever in U	J.S. 13.	Was Deced			gin? (Sp	ecify Yes or No- Rican, etc.)		ace - Americack, White,	an Indian,
92	or Ite	y Fu	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, Giv	<b>2</b> X No e		1 ☐ Yes :		Specify:		, , , , , , , , , , , , , , , , , , , ,	Spec	ifv:	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-f show the Mcdical Examiner must be motified at	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or D.	ates:	16a Dece	dent's Usua	I Occup	ation			16b. Kind of	WH]	
7	in 72 n "ne Neglic	Completed	(Specify only highes	t grade completed)	4-4-5-1	(Give	kind of wo	rk done d	du <i>rina</i> mos	t of work	ring	TOD. KING OF	Du311103341110	idatiy
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1	-40r 5+)	SALE	S ASS	OCIA	TE			. RE	TAIL	
g	be filed tat Hygid d other event, I	Be	17. Father's Name (First, Middle, L	.ast)					18. Mothe	ər's Nam	e (First, Middle, M	faiden Suma	ime)	
Maryland	should but Ment marked	2	JAMES GEORGE					(=)			IMMONS	0: 7		2 1 1
Mai	d 2 sho th and 7 Is m traum		19a. Informant's Name/Relationsh								al Route Number,	_		Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heatth and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a or 28e-f show other traumetic event, the Medical Examiner must be notified at		DAVID P. HIGDOR  20a. Method of Disposition	I/ HUSDAND	20b. F	Place of Dispo	sition (Nan	ne of			ASTON, MI Date 2	20c. Location		wn, State
OE.	Pages nent of nt: If it iry or o	Ιi	1 ☐ Burial 2 XCremation 1 ☐ Donation 5 ☐ Other (Sp		State	cemetery, crei ESAPEA	-		1	TTR 8	3/2/2006	STEV	FNCVII	LLE, MD
Baltimore,	permit. Pages Department of I Importent: If it eny injury or of once.	li	21. Signature of Emeral Service I		//	22	2. Name an	d Addres	ss of Facili	ty				
<b>m</b>	88 5 8		5	15la	al		200 S	. HA	RRISC	IN S	IN & NEWN L EASTON,	MD 2	1601	HOME PA
J	Pnysician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that conly one cause on e	aused the dear	th. Do not en	ter the mod	e of dyin						Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to	or as a consec	quence of):		~	1		eare when	/ -		
	Examiner	L	Sequentially list conditions,	b. Dunte	Reus	rout	Va	nac	y X	evel	- wed	EUS	-	3 mg
	ted	Examiner	Sequentially list conditions, and a sequentially list conditions, and a sequential seque	5.00	on as a conseg	grenze org.					V			
Ć,	be executed ician and buriat-transit	Exar	resulting in death) Last	C. Due to	or as a consec	quence of):								
1760,	ys e	icai		d										
89	ntifica ing ph e as th	Med	IF FEMALE:											
Вох	death certifica e attending ph ed for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Feta	al death 3[	Ectopic pr		,				ate of delive Month	ry Day Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregn 9⊟Unkne	ant at time of c own	death 5L	Other (sp	өспу)		-				
P.0	The law requires that the tte has been signed by the bage 2 should be detache		Part II. Other significant condition	ns contributing to de	ath but not res	sulting in the u	ınderlying c	ause giv	en in Part		23e. Did tob	acco use co	ntribute to th	e cause of death?
Records,	quires in sign	ed by	Rheumoton	P askint	5						1 ☐ Ye	s 2 No	3 Prob	ably 4 □Unknown
900	aw requir is been s 2 should	Completed	hower G1	Bleadin	<b>&gt;</b>						24a. Was ar autops	24b	. Were autop	osy findings available inpletion of cause of
Ä		mo.			)						perform 1 Yes 2	100?	death?	2 No
Vital	ilcien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	S. Control				0.1		of Deal	th (Check only one	9)		
of	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 🔲		ER/Outpatier	_	A Oth	4 2 11	ursing H	ome 5 Reside		- ' ' '	′)
uo	ding F h. After I funera	tion	1 ☑Natural 5 ☐ Pendin	g (Mon	th, Day Year)	Injury	M	Wor	yan k? Yes 2. □	No	200. Describe no	w injury occu	21160	
Division	l or Attending after death. Director: After I in by the fune	fica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place	of Injury - At h	nome, farm, st	reet, factory	, office			28f. Location (Str		nber or Rura	I Route Number,
Š	al or safter	Certification:	4 Homicide	buildi	ng, etc. <i>(Speci</i>	ny)					City or Town	, State)		
	To the Hospital or Attanding Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the Examiner: On the b and man	best of my knoasis of examination	owledge, deat ation and/or in	th occurred evestigation	at the tin , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the ca red at the time, da	use(s) and nate and place	nanner as st e, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 1	. 1 11	1 10	290	. Licens	e number		29	d. Date sign	ed (Month.	Day, Year)
•			▶ Wdi	Lan HT	wolf	pril		10	NES,	115		8/	2/0	6
	4-		30. Name and address of person	who completed caus	e of death (He									
	Sta	lle to	31. Date filed (Month, Day, Year)	OD, JR. M	D 5	O1 DUTO ature	CHMAN:	S LA	NE, E	ASTO	N, MD 21	601		
	Registr	_	AUG 0 3	- 19		A A	400	7						

			1- State of Maryland / State of Maryland /	•	artment of Hertificate of E			giene	006	258	91.
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	Year	3. Time of	Death
	Physici /Medic		Leona Irene Menke Hardesty				August	1	2006	6:15	$A^{M}$
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of D	eath	4c. C	ounty of Dea	th	
			981 Dennett Road		0ak1ar				Garret	t	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year Months Days		Min. (Month, Day	v, Year)	C	thplace (State or ountry)	<sup>r</sup> Foreign
	Director	}	212-38-5967 84 Usual Residence of Decedent	Yrs.			July 20	, 192	22  Ma	ryland	
	land	1	10a. State 10b. County 10c. City, Too	wn or Lo	cation					10d. Inside Cit	y Limits
	Mary f sh	ō	MD Garrett Oakl	and						1 ☐ Yes	2× No
	the roti	rec	10e. Street and Number	and	10f. Zip Code			10g. Citize	n of What C	ountry?	
	3a o	0	981 Dennett Road		21550			Unit	ed Sta	tac	
	me 2	ner	11. Marital Status 12. Was Decedent Ever in U.S.	13.		panic Origin	? (Specify Yes or No- ruerto Rican, etc.)		Race - Am	encan Indian.	
9	after or its	by Funeral Director	Armed Forces?  1 Never Married 2 Married   1 Two Sirve	i i	77	Specify:	ueno Hican, etc.)		Black, Whi	te, etc.	
21215-0036	n 72 hours after death with the Maryland "natural", or iteme 23a or 28e-f show golical Examinat must be notified at	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		10.05 22.100	Specity.		3,	рес <i>ify:</i> Wh	ite	
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giva	dent's Usual Occupati kind of work done du	tion uring most of	working	16b. Kind	of Business	/Industry	
121	within ene. than "	m	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired)			D. J. 1	ld - 0 -	1 1	
2	lled v dygie ther t		5+	Te.	acher	18 Mother's	Name (First, Middle,		Lic Sc	nools	
and	ntai he d	Be					• • •		ŕ		
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r freumatic event, Ine Mod	၉	Henry Arthur Menke  19a. Informant's Name/Relationship (Type, Print)  19	h Mailir	on Address (Street a	Alm	a. Ir Rural Route Numbe	Harve Gity or 1	-	Zin Code)	
Ma	d2s than treu						akland, MD	. ,		2.00007	
ē	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then other treumatic event, ILEM		20a Method of Disposition 20b. Place	of Dispo	sition (Name of		Date Date			Town, State	
D D	ages ant of it: if i		1 E3 Burial 2 Cremation 3 Removal from State	-	matory or other place Cemetery	.	/4/06	Oak L	and, M	D	
Baltimore,	permit. Pages 1 and 2 Department of Health a importent: if item 27 is any injury or other tree		21. Signature of Funeral Service Licensee	22	2. Name and Address	of Facility	74706 Burdock-Du	Uakia	inu, m	1 II	
B	Depermine Deperm		* Kathinia Sweiter		21	N. S	econd St.,	ust i	unera and.	т ноте MD 21550	5
			23a. Part1. Enter the disease, or complication that caused the death. Do shock, or heart failure. List only one cluse on each line.	not ent						Approximate Interval Betw	)
	Physician		Immediate Cause (Final							Onset and D	
7	/Medical		disease or condition resulting in death)  a. Alzheimer's  Due to (or as a consequence		pe demen	tla				yrs	
	Examiner		Sequentially list conditions b.								
	7 =	Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Oisease of Injury	of):							
	ate be executed thysician and the burial-transit	Examiner	triat initiated events								
90,	oe exectan a	Ë	resulting in death) Last Due to (or as a consequence	of):							
8760,	certificate be executed nding physician and use as the burial-transi	dlcai	d								
9 ×	death certific attending pl	/Me	IF FEMALE: 23b. Was decaded assessed 23c. If yes, outcome of pregnancy								- 111
Вох	ath or (	ian	23b. Was decedent pregnant in the past 12 months?    Section 1		Ectopic pregnancy Other (specify)			23	<ul> <li>Date of de Month</li> </ul>	•	ear
o.	0 0 0	ysic	1 Yes 2X No 9 Unknown	3	Other (specify)						
α.	requires that the der een signed by the a nould be detached f	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting	in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use	contribute t	the cause of de	eath?
ds	uires sign ld be	d b	Hypertension				1 □ Y	es 2 <b>x</b>	No 3□P	robably 4 🗆 U	nknown
Ö	- Q m	Completed					24a. Was a	an l	24b. Were a	utopsy findings a	vailable
Re	The law sete has page 2 s	mc					<ul> <li>autop</li> <li>perfor</li> </ul>	med?	prior to death?	completion of ca	use of
a	icien: Th certificate rector, pag	e Cc	25. Was case referred to medical			OF Diago of	1 ☐ Yes Death (Check only or	2 <b>X</b> No	1 ∐ Yes	2 No	
5		To B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 EP/0	utnatier	Othor		ng Home 🔀 Resid	-3/-	Other (See	ucifu)	
o	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b.	Time of	28c. Injury	at	28d. Describe h			city)	
ion	ath. r: Aft e fun	atio	Matural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work¹ M 1 □ Y	es 2 □ No					
Division of Vital Records,	Atte er de: racto by th	t tic	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	arm, str	eet, factory, office		28f. Location (S City or Tow	Street and I	Number or R	ural Route Numb	er,
Ö	tei ol rs aft ei Dii ed in	Certification:	January,								
	To the Hospitel or Attending PP within 24 hours after death. To the Funerel Diractor: After the completely filled in by the funeral	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge of the control of the basis of examination a one of the control of the basis of examination a one of the control of	ge, deatl nd/or in	n occurred at the time vestigation, in my opi	e, date and p nion, death o	lace, and due to the o occurred at the time, o	cause(s) ar	nd manner a ace, and du	s stated. s to the cause(s)	
	o the	Med	29b. Signature and title of certifier	_	29c. License	number	2	29d. Date s	signed (Mon	h, Day, Year)	
	F > F 0		I and to hoter		D300	35	C	0-8(	-200	6	
			30. Name and address of person who completed cause of death (Item 23a)	(Type,	Print)						
			Donald R. Richter, M.D. 153			Driv	e Oaklan	nd, M	ID 21	550	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 2006	A	60680						

			1- State of Maryland / Department of Heal Certificate of De		Rag	g. No.	)6	25895
	Physici	an	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of Death
1	/Medic	al	Naomi Groomes Johnson  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc	enation of Dooth	July	23 2 4c. County	2006	7:35 A M
	Examin	ier		lver Spi	ino	_	_	omery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign
и	Director		214-18-7195 100 Yrs.		Apr. 26,	1906		yland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				1	0d. Inside City Limits
	Maryl -f sho	ţ	Marvel and Horsey J	lumbia				1X Yes 2 □ No
	r 28a	Director	Maryland Howard Co.  10e. Street and Number 10f. Zip Code	TUMDIA	10	g. Citizen of V	Vhat Coun	itry?
	th wit		5665F Harpers Farm Road	21044		Unit	ted S	tates
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		e - Americ k, White,	ean Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No S ☐ Year or Dates:	Specify:		Specify	<i>r</i> :	Black
9	4 within 72 hours after death with the Maryland jiene. I then "natural", or tlems 23a or 28a-f show The Medical Examinat must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation			6b. Kind of Bu	siness/Ind	dustry
215	within 7 lene. than "n	Completed	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	ng most of workli	ng			
21	e filed with Il Hygiene. other thai		2 Social W		/First Adiabatha Ad		ernme	nt
anc	e d la b	Be	17. Father's Name (First, Middle, Last)  William Groomes	s. Mother's Name	(First, Middle, Maxth	a Harr		
Maryland 21215-0036	is 1 and 2 should be for Health and Mental Filem 27 is marked of other traumatic even	၉	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and</i>	Number or Rura				Code)
N	1 and 2 Health a tem 27 is		Barbara Johnson Clegg/Daughter 2901 Memory La	ane, Sil	lver Spr	ing, MI	20	904
ore,	ges 1 a t of He If item or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State		ate 2	0c. Location -	City or To	wn, State
ij			'4 Donation 5 Other (Specify) Christ Episcopal Cl		/2006	Colur		
Baltimore,	permit. Pag Department Important: I any injury o once.		110000	nning Ro	ewart Fu	Wash.,		
			23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, st shock, or leart failure. List only one cause on each line.	such as cardiac o	r respiratory arres	st,		Approximate Interval Between Onset and Death
	Pnysician /Medical	6.1	Immediate Cause (Final disease or condition a. Atherosclerotic Cardiovase resulting in death)	cular Di	isease			Years
ı	Examiner		Due to (or as a consequence of):					
	V 500	je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	cuted nd ransit	Examine	Cause, Litter Underlying Cause (Disease or injury that initiated events  c.					
ő,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
8760,	ate hy:	dica	d				-	
эх 6	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as!	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Dat	e of delive	erv
Box	death e atter	iciar	in the past 12 months?  1			Mo		Day Year
P.0	by the destached	hys	9 Unknown					
	res that igned b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.		cco use conti	ribute to th 3 □ Prob	ne cause of death?
orc	w requir been si should	eted			7			
Records,	has the	Completed			24a. Was an autopsy performi	l r	Vere autor prior to cor death?	psy findings available mpletion of cause of
Vital		e Co	25. Was case referred to medical 26	C Place of Dooth	1 Yes 2	No 1	Yes	2 No
Ş	Physician: this certific ral director,	0	examiner?				er Date	hter's Hom
υot		n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 18b. Time of 28c. Ti		28d. Describe how			,
Sion	Attending r death. ector: After oy the fune	catic	2 Accident investigation M 1 Yes	3 2 □ No				
Division		Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Stre City or Town,		er or Rura	I Route Number,
	spital or ours afte leral Dir filled in		29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, c	date and place, a	and due to the cau	ise(s) and ma	nner as st	ated
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	(Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion and manner stated.	on, death occurre	ed at the time, dat	e and place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier b. Man 42 29c. License nu	umber	290	d. Date signed	(Month,	Day, Year)
	5		Italicia lomske my mx D5	1916		July	28,	2006
1/2	- (3)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 011	0.100	D - 1		MD 00050
	Sta	ate.	Patricia Tomsko Nay, M.D. 11119 Rockvil:  31. Date filed (Month, Day, Year)	Te Like	G-100,	KOCKVI	гтте,	אַט אַט עואַ 208
	Registr		AUG 0 2 2006 Bleed & Species					

06-05388 Terrell D. Jones

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Redistar Terrell D. Jones  1. Decedent's Name (First, Middle, Last) Terrell D. Jones  4. Facility Name (if not institution, give street and number) Prince George's County Hospital  5. Social Security Number Funce George's County Hospital  5. Social Security Number Former George's County Hospital  6. Sex Former George's Prince George's County Mospital  7. Age (in yrs. last birthday) Former George's Prince George	or D. C. City Limits 2 No
4a. Facility Name (if not institution, give street and number) Prince George's County Hospital  5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State Foreign Country) Washington Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	n D C. City Limits 2 No
Prince George's County Hospital  Cheverly  Prince George's  Social Security Number  5. Social Security Number  5. Social Security Number  5. The social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months  Days Hours Min.  Oct. 26, 1984  Washington  10d. Inside  1 y Yes	n , D . C. City Limits 2 No
Director  577-11-2225  1 x M 2 F 21 Yrs. Months Days Hours Min. Oct. 26, 1984 Foreign Country)  Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location 10d. Inside	n , D . C. City Limits 2 No
10a State 10b. County 10c. City, Town or Location 10d. Inside	2 No
Maryland Prince Georges Capitol Heights    1	lack,
106. Street and Number 1408 Opus Ave.  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	_
11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1	_
Specify  1 Yes 2 No specif	none
15. Decedent's Education (Specify only highest grade correpted)  16. Decedent's Education (Specify only highest grade correpted)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  19. Informant's Name/Relationship (Type, Print)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Informant's Name/Relationship (Type, Print)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Informant's Name/Relationship (Type, Print)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19. Informant's Name/Relationship (Type, Print)  19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20. Place of Disposition (Name of cemetery, crematory or other place)	none
Property of the part of the pa	none
17. Father's Name (First, Middle, Last)  Donnell Cobb  18. Mother's Name (First, Middle, Maiden Surname)  Hope Jones  19a. Informant's Name/Relationship (Type, Print)  Hope Jones / Mother  19a. Informant's Name/Relationship (Type, Print)  Hope Jones / Mother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1408 Opus Ave. Capitol Heights, Md. 20743  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	
To plan by the part of the par	
Hope Jones / Mother   1408 Opus Ave. Capitol Heights, Md. 20/45	
200. Welling to Disposition 2 Removed from State crematory or other place)	
Harmony Memorial ParkJuly 28,2006 Landover, Md	
200. Method of Disposition  1	- 11
We can start shock or heart. Accresion	4 /
failure. List only one cause on each line  Medical  Discrepance of Chapter of	Onset and eath
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, b	
cause. Enter Underlying Cause (Disease or injury that initiated	
events resulting in death) Last Due to (or as a consequence of).	
Deputy of the property case of	
9 of the second	Year
Wonth Day  2 3b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (Specify)  On part 11. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  2 Fetal death 3 Ectopic pregnancy Month Day  Other (Specify)  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
The state of the cause of the c	death?
O d sain of the sa	
Ye for the law reduces a law autopsy period to completion of death?  1 ✓ Yes 2 No 1 ✓ Yes 2	
1 ✓ Yes 2 No 1 ✓ Yes 2  25. Was case referred to medical examiner?	No
25. Was case referred to medical examiner?  1 Very es 2 No  25. Was case referred to medical examiner?  1 Very es 2 No  26. Place of Death (Check only one)  27. Place of Death (Check only one)  28. Was case referred to medical examiner?  1 Very es 2 No  28. Was case referred to medical examiner?  1 Very es 2 No  28. Was case referred to medical examiner?  1 Very es 2 No  29. Residence 6 Other	
u	
Von the part of th	mber, City
3 Suicide 6 Could not be determined (Specify) Sidewalk  4 Homicide  4 Homicide  29a Certiffer (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started	ı, DC
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (hotek only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (hotek only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (hotek only one)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (hotek only one)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (hotek only one)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (hotek only one)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  And manner stated (hotek only one)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  And manner stated (hotek only one)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  Span Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)  Span Certifier 1 Certifying Physician: To the best of my knowledge	
29b. Signature and title of certifier 29d. Date signed ( <i>Month, Day, re</i>	ir)
O.C.M.E. July 25, 2006	
30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State State Registrar  31. Date filed (Month, Day, Year) Registrar  32. Registrar's Signature	

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		For State			Certific	ate of	Death		75	Reg N	0 ')	Du	
Physician/ Medical Examine	1	. Decedent's Name (First, Midd	le,Last)	L. J	ack.	son			2. Date of Month Augu		y Year		3. Time of Death ジ 🍃 1840 hrs
<b>S</b>	4	a Facility Name (if not instituted Prince George's Hosp		nd number)		41	c. City, Town, o	r Location of [	Death		4c. County o Prince G		3
Funeral Director	-	Social Security Number 579 - 52 - 1914	6 Sex		66	hday) Yrs.	If Under 1 Yes Months Day			e of Birth(M		9. Birth Foreign Cour	place (State or Washington htry)
Jand fshow any once,	1	Journal Residence of Decedent  Oa. State  10b. County		10	c. City, Town	or Location	n 4 40 17 101. Zip Code	, D.	C.				10d Inside City Limits 1 Yes 2 No
ith the Maryland  23a or 28a-f show notified at once.	2 1	0e. Street and Number  507 58 Hr	Stree	t, N.			10t. Zip Code	0019		10g. C	Citizen of Wh		ry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sh matic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director			arried Arm	s Decedent Evened Forces? Yes 2 ve Year	No	If Ye	Decedent of Hi s, specify Cuba Yes 2 No	n, Mexican, P specify:	uerto Rican, et	:c.)	White Specify:	, etc. <i>B</i> /	an Indian, Black,
5-0036 led within 72 hours Hygiene other than "natur the Medical Exam	n paradili	15. Decedent's Education (Spe Elementary/Secondary (0-12)		ege (1-4 or 5+)		during mo	s Usual Occupa st of working life on for y	e. DO NOT us	se retired)		Nind of Bus		ndustry
ID 21215-003 should be filed with and Mental Hygiene 77 is marked other that it event, the Mer To Be Com	2 1	7. Father's Name (First, Middle		) /1					Name (First, Mi Her				
2 H E W	2 1	George 9a. Informant's None/Relations Toyce Jackson	Satterwh	ite (Sis	ter) 19	b. Mailing 1106 W 43	Address (Stre	Place Digital	er or Rural Rou	te Number,	City or Towr	State, I	Zip Code)
imore Pages 1 nent of H lant: If i or other	ľ	1 Burial 2 Cremation  Donation 5 Other S	n 3 Remo		ZUD. Flace	oi Disposii	1011 (14	cilicies y,	Date	120	C LUCATION -	City Of 1	OWII, State
		21. Signature of Funeral Service  Alph E  3a Part I. Ent. r the disease, or	Will	that caused the	767	22. Na 181. ot enter th	ame and Address A POTO M e mode of dvind	ss of Facility  I / / / or  OC / Po	Je . SE	. Wa	Seling	ken t	Md.  De 20003  Approximate Interval
Physician /Medical cxaminer	S	failure. List only one cause immediate Cause (Final disease or condition resulting in death)	e on each line. e a. Athe:		cic card		cular dis					Į	Between Onset and Death
	ا ا	Sequentially list conditions, if any, leading to immediate		or as a consequ	ence of):								
ed nsit	Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	or as a consequ	ience of):	<u> </u>							
execut an and al - tra	edical	X UNPENDED	AMEN		#23a 27	28a-f	perME,g8	 58 8/10/	/ns тт				-
	∑ I '	F FEMALE: 3b. Was decedent pregnant in t past 12 months?  1 Yes 2 No 9 Ur	the 1 4	f yes, outcome Live birth Pregnant at tim Unknown	of pregnancy	2 Fet	al death 3 ner (Specify)				23d Date of Month	,	ay Year
aw requires that the death certifications been signed by the attending 2 should be detached for use as	2	Part II. Other significant condi	tions contribu	iting to death b	ut not resultir	ng in the u	nderlying cause	given in Part					ne cause of death?
Division of Vital Records, P.O. real or Attending Physician: The law requires that the range and the range of the foreign of the foreign and pirector, page 2 should be detach	Completed				-			T.	-	Was an autopsy performed Yes 2	1? d		opsy findings available mpletion of cause of
Vital I	o Re	25. Was case referred to medic examiner?  1 ✓ Yes 2 No	Hospital:	I Inpatient	2 <b>V</b> ER/0	Outpatient		Othor	Nursing Home		idence 6	Other:	
n of Nding Phy	- 1	27. Manner of Death	. 1	Date of Injury (Month, Day, Year	1.7	Time of Ir	10	ury at Work?	do I		injury occurre		
Division of Vital Rectivities of Vital Property of the Hospital or Attending Physician: The lawithin 24 hours after death.  Control the Funeral Director: After this certificate I completely filled in by the funeral director. page	Certification:	2 X Accident Investigation   3 Suicide 6 Couldet   4 Homicide	estigation 286				) pm   t, factory, office	Yes 2 XX building, etc.	28f. Loc	ation (Stree	et and Number	er or Rura	environment al Route Number, City creet, N.E.
o the Hosy athin 24 hc o the Func	ल		Physician: To the aminer:On the and ma										
#H	ž	29b Signature and title of certif					į	nse number			id. Date signi ugust 4, 2		th, Day, Year)
-	-	30 Name and address of perso Ling Li, MD Assist	n who complete ant Medical				t, Baltimore	, MD 2120	)1				
Sta Registr		31. Date filed (Month, Day, Year	Been	32. Registrar's	Signature	2							
University Revolution	-37	nou ·			Ó	RIGINA	ŭ.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARY GENEVIA JONES-REID JULY 24 2006 00:48 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Yrs. Director 246-32-4704 80 OCT 18 1925 NORTH CAROLINA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked othar than "natural", or iteme 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 X Yes 2 No Director LARGO PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zin Code U.S.A. 20774 10110 CAMPUS WAY SOUTH # 304 by Funerai 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∰Yes 2 □ No AIRFORCE
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2K No Maryland 21215-0036 BLACK Specify 3 Widowed 4 Pipivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY GOVERNMENT 2 YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I HATTIE BOWDITCH ပ ARTHUR O. SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 271 WILLOW DRIVE BREVARD, NORTH CAROLINA 28712 f Health FLETCHER/NIECE Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location · City or Town, State Department of H important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERAN'S 7/31/2006 CHELTENHAM, MARYLAND 21. Signature of Full Practi 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Encephalopathy /Medical Examiner Alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed bacteremia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2₺ No has failure renal to 1□ Yes مدر 28 No Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 🔼 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 816400 Baren R BROW 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN R. BROOK M.D. Hosp. Center Prince George's 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 . Registrar's Signature 31. Date filed (Month, Day, Year) State 2 8 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month JULY **Physician** 2006 ANDREW JACKSON 2:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MILLENNIUM FRANKLIN SQUARE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. DEC 18 5. Social Security Number 6. Sex 1 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 214-58-0495 54 Director MARYLAND Usual Residence of Decedent nit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland aritment of Health and Mental Hygiene.
ortant: if Item 27 is marked other then "natural", or Items 23s or 28s-f show injury or other treumatic event, the Madical Examinat must be natilited at 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits 1 X Yes 2 No LOTHIAN Directo MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 20711 1232 MARLBORO ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE LABORER 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN JACKSON SR. MARY BRENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6103 ARMOR DRIVE CLINTON, MARYLAND 20735 JOHN JACKSON JR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/29/2006 RIVERDALE, CREMATORY 4 □ Donation 5 □ Other (Specify) RIVERDALE CREMATORY 21. Signature of Funeral Service Licens 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final / disease or condition resulting in death) Con car **Physician** Squamous /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 No 2 No or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 virsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this Alter thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident ector: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after unerel Dire 4 ☐ Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Do062634 25 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN A. AWAN COLUMBIA HICKORY RIDGE RA MD 10802 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 8 2006 Registrar

December Name Prox (Moths Law)   December Name Prox (Moths Law)			4	For State Registrar			State of	Maryla	nd / Dep <i>Ce</i>	artmen				lental Hy	giene Reg. No.		6	25901
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A continue of the control of the c		1 and Healt em 2						20b	Place of Disp	osition (Nai	ne of		_					
Physician Medical Examiner  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each ine.  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  1 MYCCAROINL INPARCITION  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINLINE  2 MYCCAROINL	<u>ا</u>	ages ant of it: If It		1 XBurial 2	Cremation		emoval from S	State	-				3-3-	06	Ox	ford	, P	4
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IFFEMALE: 23b Was deceded pregnant in the past 12 months? 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown   23d. Date of delivery   Month Day Year   1   Yes 2   No 3   Probably 4   Unknown   24a. Whs an autopsy performed? 1   Yes 2   No 3   Probably 4   Unknown   24a. Whs an autopsy performed? 25b. Was case referred to medical examiner? 25c. Place of Death (Check only only 1   Yes 2   No 2   N	30,	oe exe cian a vurial-t	Ex	resulting in death) L	.ast		Due to (	or as a cons	equence of):									
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24a. Was an autopsy prior to completion of cause of death?  24a. Was an autopsy prior to completion of cause of death?  24a. Was an autopsy prior to completion of cause of death?  25. Was case referred to medical examiner?  1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury at North, Day Year)  28. Date of Injury at North, Day Year)  28. Place of Death (Check only one)  28. Date of Injury at North, Day Year)  28. Date of Injury at North, Day Year)  28. Place of Death (Check only one)  28. Location (Street and Number or Rural Route Number, determined between the building, etc. (Specify)  28. Place of Death (Check only one)  28. Location (Street and Number or Rural Route Number, determined between the building, etc. (Specify)  28. Place of Death (Check only one)  28. Location (Street and Number or Rural Route Number, determined between the time, date and place, and due to the cause(s) and manner as stated.  29. Signature and title of certifier  29. Day Signa		death	siciar	in the past 12 to 1 Yes 2	months?		4□Pregn	ant at time o								Month	ı	Day Year
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This part of the state of the s	alF			05 111										1 ☐ Yes	2 No			2UNo
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number, City or Town, State)  28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number, City or Town, State)  28b. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  TULY 31, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DANID 6AL-EL 30H-306 North Street Sulf= 32b. License MARCHEL 30H-306 North Street 32c. Injury at Work? 1 Yes 2 No 28b. Liquity at Work? 1 Yes 2 No 28b. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred 2	ξ	sicier certif recto	o Be	examiner?			fospital:	nnationt 2	□ EB/Outpatr	ant 3 🗆 D	Oth	or.				S Other	(Specif	(v)
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DAVID 6AL-EL 304-306 North Street Sulta 43 ELKRW MARK-WAD 21931	Ĭ	ter de lirecto n by ti	rtific							treet, factor	y, office			28f. Location City or T	(Street an own, State	d Number )	or Rura	I Route Number,
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				31. Date filed (Mon	th, Day, Yea	r)				who	•							

				partment of Health and Mertificate of Death	Reg.	- 7 Hun 754117
ı	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Richard Alan Kramer		2. Date of Death Month July	30 2006 9:08 p M
	/Medic		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July	30 2006 9:08 p M 4c. County of Death
			7600 Carley Dr.	Port Tobacco		Charles
H	Funeral Director		5. Social Security Number 079-38-8625 6. Sex 15M 20F 56 Yrs.	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Sept. Day14	9. Birthplace (State or Foreign Country) NJ
	land ow		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	a-f eh	ctor	MD Charles Port T	'obacco		1 ☐ Yes 2Ã No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "nature!', or items 23a or 28a-1 ehow event, I'm Medical Examinat rival be notified at	il Director	7600 Carley Dr.	10f. Zip Code 20677	10g.	Citizen of What Country? USA
	r death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	ors afte	by F.	1 ☐ Never Married 2夕 Married 1 ☐ Yes 2 分 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: USA
215-0036	72 hou	eted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ina 16t	b. Kind of Business/Industry
727	e filed within al Hygiene. I other then " vent, the Me	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOTuse retired) ttorney		Legal
פ	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Mai	den Surname)
<u> </u>	should be nd Mental marked o umatic eve	ဥ	Sigmund Kramer  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	Annett ling Address (Street and Number or Run	e Newmar	
<u>8</u>	s 1 and 2 should if Health and Men Item 27 le marke other traumatic	1 15		Carley Dr. Por		
altimore, Maryland 21	0 0		1 Li Buriai 2 LiCremation 3 Li Hemoval from State	ematory or other place)		c. Location - City or Town, State
E	permit. Pag Department Important: I eny Injury o		4 Donation 5 Other (Specify) Brinsfi			Charlotte Hall,M
e B	Dep Impo	5		<b>AREHART ECHOLS</b> P.O. Box 567 La		
	Physician physician and physic	Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Westernation  Due to (or as a consequence of):  b.   Due to (or as a consequence of):  c.  Due to (or as a consequence of):	ercenoma lun		Approximate Interval Between Onset and Death  Grant Gr
. Box 68/60	sath certific ettending p for use as	ician/Medical	1 Yes 200 No. 4 Pregnant at time of death 5	□Ectopic pregnancy		23d. Date of delivery Month Day Year
5	law requires that the de as been signed by the 2 should be detached	/ Physi	9 ☐ Unknown  9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to lihe cause of death?
rds	en sign	ed by	cemphysema.		1 Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	e lay has je 2	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
/Ital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		h (Check only one)	
	Phys this ral dii	J: To	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Jeath 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending		me 5 Residence	e 6 Other (Specify)
<u></u>	Attending in death.	ation	2 Accident investigation	Work? M 1 Yes 2 No		
Division of	or At fler d Direct in by	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S.	t and Number or Rural Route Number, state)
	H 4 H 9 H	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of ceptities	29c. License number		Date signed (Month, Day, Year)
)			MMMM/b>	D46419		7/31/06
1	BIN		30. Name and address of person who completed cause of death (Item 23a) (Type Charlene A Letchford, MO 404 C	, Print) houses St Ca Pla	eta MD	20646
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type Charlens A Lefthford, MO 404 C 31. Date filed (Month, Day, Year)  AUG 0 2 2006  32. Figistrar's Signature	berli		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:20 AM **Physician** 26 2006 /Medical ounty of Death 4b. City Town, or Location of Death Examiner TRUNG! edica 5. Social Security Number 6. Sex **Funeral** 146 - 14-994 Usual Residence of Decedent Days Min 1 M 2 F Director the Maryland 10a State 10b Coun 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f ehow if Health and Mental Hygiene.
Item 27 Is marked other then "natural", or Items 23s or 28s-f ehov other traumatic event, the Medical Examinar must be notified at 1 Pres 2 No Completed by Funeral Director owie Mary Mary and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the N. Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural eny highry or other traumation." 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?
1 Yes 20 No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 24 No 3 Widowed 4 □ Divorced lack 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) URSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden To Be TRNR er SOL e/Relationship (Type 19b. Mailing Address (Street and Number or Rural Boute Number, City of 20b. Place of Disposition (Name of cometery, crematory in or er p 20. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 29,2006 Harmony 21. Signature of Funeral Service Name and Address of Facility Homes 38 Marlboro 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of) LED Examiner DEM ENTIA Securitially list of dilices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Z No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANEMLA 1 Yes 2 No 3 Probably 4 Unknown DIRRITO GA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 No 2 No 1 🗌 Yes funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No Diractor: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funaral Dirac 4 Homicide 29a. Certifier Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 10051437

State Registrar

BLIDTE OKEDWO DARCT 31. Date filed (Month, Day, Year) 3 1 2006

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAMC 2. Registrar's Signature

, 26, 1956

			For State	State of Marylan				Mental Hy	giene	000	OFOOL
			Registrar	4	<i>C</i> (	ertificate of	Death	2. Date of De	Reg. No.	UUD	25904
	Physici /Medic		1. Decedent's Name (First, Middle, Las $James \qquad G. \label{eq:James}$					Month July	Day 27	2006	3. Time of Death 1:55 A
	Examin		4a. Facility Name (If not institution, give	street and number)	_		r Location of Death	1		ounty of Death	
27			Suburban Hospit		la ad birdhala	Bethesd:	a If Under 24 Hrs.	2 Date of Ric		ntgome	··
	Funeral Director		5. Social Security Number 6. Sec. 216-84-1515	7. Age (In yrs. M 2 F 45	Yrs.	Months Days	Hours Min.	8. Date of Birl	60° r)	Cou	place (State or Foreign intry) nington, D.C.
	pu k		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ly, Town or	Location					10d. Inside City Limits
	Aaryla F sho	ō	VA Arlingt		Arling						1 ☐ Yes 2 🛣 No
	the h	rect	10e. Street and Number	511	JL TILLE	10f. Zip Code			10g. Citizer	n of What Cou	intry?
	th with 23s or	alDi	1915 N. Roosevelt	St.			22205			USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural," or items 23s or 28s-f show other traumatic event, the Medical Examinating a notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	l.S. 11	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	1	Race - Ameri Black, White pecify:	
15-0	natur	Be Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec	cedent's Usual Occup ve kind of work done b. DO NOT use retired	ation during most of wor	king	16b. Kind	of Business/Ir	ndustry
212	iene.	dmo	Elementary/Secondary (0·12)	College (1-4or 5+) 5+		onomist	2)		Dept	. of L	abor
٦	al Hyg	3e C	17. Father's Name (First, Middle, Last)				18. Mother's Nan			ımame)	
ylaı	Duid b Menti	2	John J. Lynch					ny J. B			
Maryland	12 sh h and 7 is m traum	1	19a. Informant's Name/Relationship (7	•		illing Address <i>(Street</i> N. Roose					p Code)
	1 and Healt tem 2		Christine McDanie 20a. Method of Disposition	20b. F	Place of Dis	position (Name of		Date Date		tion - City or T	own, State
ē.	Pages nent of int; If i		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoyal from State		rematory or other place on Center		9/06	Chan	tilly,	VA
Baltimore,	permit. Pages 1 Department of H important; if Ite any injury or ott		21. Signature 1 Funeral Service Licen	See Mario	/ 1	22. Name and Addre		sonBlvd.	Arl.	, VA 2	2203
			23a, Part1. Enter the disease, or companies shock, or heart ailure. List only	olications that caused the deat	th. Do not e	enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	E	BRA	IN C	PANCE	7TE			2 Years
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						- / -
	, -	ē	Sequentially list conditions, if any, leading to intributional cause. Enter Underlying Cause (Disease or injury	b. — Dus to (or as a conseq	uanca of).						
90	cuted	Examiner	that initiated events	C.							
7-6	ficate be executed physician and s the burial-transit	Ex	resulting in death) Last	Due to (or as a conseq	(uence of):						
18760, 68760,	cate b physic the b	edicai		d							
7/ 30x 6	aath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	al death	3 □Ectopic pregnancy			230	d. Date of deliv	very Day Year
240	tha des	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐ Unknown	death	5 ☐ Other (specify)					32,
. / S, P	res that tha digned by tha	by Pt	Part II. Other significant conditions o	ontributing to death but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ğ	v require been sig should b							10	Yes 2 X	No 3∏Pro	bably 4 □Unknown
以のは al Record	Attanding Physician: The law requires that tha death certif reasth: reactor. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Completed						24a. Was autop perfo 1 Yes		24b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 No
Vita V	ysician: Th iis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea				
£ 10	Phys r this ral dir	6	1 Yes 200 No 27. Magner of Peath	1 Inpatient 2	ER/Outpat 28b. Time	ient 3 DOA	er: 4 ☐ Nursing H	ome 5 Resi			rfy)
6	ith. :: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injur	y Wor	k? Yes 2∐No				
ج ج Divisi		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia		street, factory, office		28f. Location (. City or To		Number or Rur	al Route Number,
~	ipital or A ours after isral Direction by										
SAN	Fe the	edicai	29a. Certifier	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, de ation and/or	eath occurred at the tir investigation, in my o	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) an date and pl	ace, and due	stated. to the cause(s)
17	To the within 2 To the complet	Me	29b. Signature and title of certifier	01 -		29c. Licens				signed (Month,	
			• Ame	me _		D	42518		74	42	7,2006
CR	(12)		30. Name and address of person who	completed cause of death (Item	m 23a) (Typ	e, Print)	Dioco	teor	Ro	eour	10 2082
	Sta Regist	ate rar	31. Date filed (Month, Day, Yeer)  JUL 3 1 2006	2. Registrar's Signa	ature	whi !					
			00L 0 2 1000								

State

Registrar

31. Date filed (Month, Day, Year JUL 2

gistrar's Signature

32

2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 'a M **Physician** July 31, Bertha Lowe 5:40 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6442 Nanticoke Road Wicomico Ouantico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year 11/6/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕶 F 78 243-32-9488 North Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
net: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or hitems 23a or 28a-f show any or other traumatic event, the Muclical Exerciting in an invalidated at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Wicomico Ouantico Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6442 Nanticoke Road 21856 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify white Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hoyle Hartman Ardee Conrad 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan N. Stevenson/daughter 921 Sumac Circle, Salisbury, MD 21804 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Springhtin' menory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 8/4/06 Hebron, MD \* 4 □ Donation 5 □ Other (Specify) Gardens 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Que ings 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVI) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Exactly designed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó Month Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No Records, P.O. eu! detached 9 Unknown 9 Unknown ፭ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Onknown 3 Probably 1 ☐ Yas 2 ☐ No. 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed; certificate 1 Yes 2 No 2 2 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify Group Home 1 Yes 2 No Hospital: ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification; 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A

Completely filled in by the fu death. м 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 047094 8/2/06 NOKS M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBURY MD 21804 NATESAN 5 DIVISION VEL 1415 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 0 2 2006 Registrar

		1 - For State Registrar		State of Ma	aryland /	-	artment of F		-	Reg. No.		.,
Physi /Med		Decedent's Name (First, Manne)  Naomi	E.		Lepl	еу			2. Date of De. Month Aug 10,	2006	Year	3. Time of Death 3:40pm м
Exam	iner	4a. Facility Name (If not instituted as 108 W. Seco					4b. City, Town, o	or Location of Dea land	th	Allega Allega	y of Death any	
Funera Directo		5. Social Security Number 215-36-9844	6. Sex 1 ☐		9 (In yrs. last t	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		<sup>h</sup> , <sup>r</sup> 1914	9. Birthr	place (State or Foreign
aryland ahow det	_	Usual Residence of Deceder  10a. State 10b. Co	unty		10c. City, To		cation perland				1	0d. Inside City Limits
n the Mirr 28a-f	Director	MD A	legany			Julik	10f. Zip Code			10g. Citizen of	What Cour	1 □XYes 2 □ No entry?
sath wit s 23a o	erai D	108 W. Seco		eet 2. Was Decedent I	Turnin III C	40.1		21502			SA	To Para
BAITIMOFE, IMARY/SANG Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any Injury or other traumatic event, the Medicul Event en must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐  3 ☐ Widowed 4 ☐ Divo	Married	Armed Forces?  1  Yes 2 N  If Yes, Give X  Year or Dates:			Vas Decedent of H f Yes, specify Cubi I ☐ Yes 2 No	an, Mexican, Puel	opecify Yes of No- to Rican, etc.)		ce - Americ ick, White, <sup>fy:</sup> <b>whit</b>	etc.
Z1Z13-UU36 ad within 72 hours af giene. or than "natural, or t, the Medicul Exert	Completed	(Specify only h		completed)	16	a. Deced (Give life. I	lent's Usual Occup kind of work done OO NOT use retired	nation during most of wo	orking	16b. Kind of B	Business/In	dustry
d Z IZ I	Comp	Elementary/Secondary (0-		College (1-4or 5	+)		naker			own ho		
id be fit ental H ked oth	To Be	17. Father's Name (First, Michael Howard At							<sub>me (First, Middle,</sub> Norris Atl		me)	
Marytand nd 2 should be filt lith and Mental H; 27 is marked oth	-	19a. Informant's Name/Relati	ionship (Typ	e, Print)	19	9b. Mailin	g Address (Street )5 Knob F	and Number or R Road	ural Route Numbe	or, City or Town Derland	, State, Zip	, <i>Соф</i> ) 21502
Pages 1 an nent of Heal nut: If Item 2 ury or other		20a. Method of Disposition 1 Burial 2 Cremat	ion 3 □Re		cemet	of Dispo	sition (Name of natory or other place emorial Ga	сө)	Date 8/14/2006	20c. Location		own, State
Dallimore, permit. Pages 1 a Department of Her Important: If Item any Injury or othe		4 Donation 5 Other 21. Signature of Funeral Ser		1 6/1	Resua		. Name and Addre	îî Funeral I				
fileate be executed  Medica  Medica  Physicien end  Is the buriat-transit	1	23a part. Enter the diseas shock, or hear failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, Isaumg to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a, or complic List only one a. b. c.	Due to (or as a Due to (or a) Due to (or a)	a consequence	9//C e of): e of):	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
= On rd	Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)	,			ate of delive	ery Day Year
The law requires that the death certaines that be death certained has been signed by the attending	Completed by Ph	Part II. Other significant con CHRONCE DB								obacco use con	tribute to th	ne cause of death? ably 4 ∐Unknown
The taw cate has b	Compl									med?	death?	psy findings available inpletion of cause of
ysiclan ysiclan s certif	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑ No	-	spital: 1 🗆 Inpatie	nt 2 🗆 ER/C	Outratien	3 DOA Oth	00	ath Check only of		ner (Specif	4
Invision of Vital necolus, to Attending Physician: The law requires I after death.  Director: After this certificate has been signs in by the funeral director, page 2 should be		27. Manner of Death	nding estigation	28a. Date of Injur (Month, Day	y 28b	. Time of Injury	28c. Injur Wor		28d. Describe h			,,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funarel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place of Inju- building, etc	iry - At home, :. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	ber or Rura	l Route Number,
To the Hospital within 24 hours a To the Funeral (completely filled	edical C	29a. Certifier 1 Cart (Check only 2 Med	fying Physical Examine	cian: To the best of er: On the basis of and manner sta	examination a	ge, death	occurred at the tin estigation, in my o	ne, date and place pinion, death occi	e, and due to the curred at the time, o	cause(s) and madate and place,	anner as st and due to	ated. the cause(s)
Toti withii Toti	W	29b. Signature and title of ce		Fig.	aath (Itam 22-	V.C.		e number 00054004		29d. Date signe		Day, Year)
) s	tate	Object Klasses	- MD			1991	E. Nation	nal Highw	ay La∀al	e MD 2	1502	
Regis	trar	AUG 3	6 200	32. Registra	w B	ROST	selv .					

<b>S</b>	*			State of Maryland		rtment of l tificate_of		nd Men		iene <sub>eg. No.</sub> 20	06	25908
	Dhysisia	_	1. Decedent's Name (First, Middle, Lest)					1	Dete of Dee Month _	Day	Yeer	3. Time of Death
A. P.	Physicia /Medica	al _	SANDRA LEE LEN				41. O't. Tax	vn, or Locatio	JG.7,		of Donah	10:15P
j	Examine	r	4e Fecility Neme (If not institution, give s							4c. County		
			CHARLES CO. NUF  5. Social Security Number 6. Sex			If Under 1 Year		PLAT A	nate of Birth	1		plece (State or Foreign
	Funeral Director			M 21XF 65	Yrs.	Months Days	Hours	Min. A I	Month, Day JG • 27	,1940	PA.	plece (State or Foreign intry)
			Usuel Residence of Decedent									
	rylen.		10a. State 10b. County		Town or Loc							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Sa-f s	2	PA. CENTRE		804	ALSBURG	•			0. 0%	4/1	
	th with the	ਰੈ∣	10e. Street end Number 504 WEST DRIVE			10f. Zip Code 168	27			0g. Citizen of V	wnat Cou	intry ?
020	72 hours after death with the Marylend natural' or flams 23a or 28a-f show oreal Examiner must be notified at	by Funeral	11. Merital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:	If	Vas Decedent of I Yes, specify Cub	Hispanic Original Hispanic Origin Hispanic Original Hispanic Origina Hispanic Origin	gin? (Specify , Puerto Rica	Yes or No- n, etc.)		ck, White	
21215-0020	in 72 hou	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16e. Deced (Give life. D	ent's Usual Occu kind of work done OO NOT use retire	pation during most ad)	of working		16b. Kind of Bu	usiness/Ir	ndustry
21,	d within glene.	E	Elementary/Secondary (0-12)	College (1-401 34)	]	HOMEMAK	ER			OWN I	HOME	
2	E T to S	Be	17. Father's Name (First, Middle, Last)					-		Maiden Sumem	10)	
yla	tic sa di	0	JOHN HENRY I					CHA W			_	
Maryland	2 sh end ls m		19a. Informant's Name/Relationship (Ty) PAUL LENKER-SI			g Address <i>(Str</i> ee WEST DR						ip Code)
	s 1 end f Health ttam 27 other to	1	20a. Method of Disposition	20b. Plac	e of Dispos	sition (Name of		and the same of th	-	20c. Location -		own, State
nor	# O -		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	natory or other pla ERLAND		PARK 8	8-15-	.06 ST	NINC	IGTON, PA
Baltimore,	世界電車	1	21. Signature of Funeral Service License		_ 22	Name and Addre	ess of Facilit	v				
ä	Deperment of the population of	1	Mich and	0 2		AYMOND A PLATA					•	
		$\dashv$	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	Do not ente	er the mode of dy	ing, such es	cerdiac or res	spiratory arr	est,	ļ	Approximate Interval Between
id	Physician		Shock, of Healt failule. List only of	o cause on econ inte.	LA F	_					1	Onset and Death
Ą	/Medical Examiner		Immediate Cause (Final disease or condition		1-1-1						1	
F		<u>_</u>	resulting in death)	Due to (or a	s a conseq	uence of):						
	nsit	Examiner	€ t	C+	ヤリ	a t				1.4	<u> </u>	
Ć,	ficate be executed physician and is the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	h or	nic	Can	de'on	140P	athy		
58760,	ysicia ysicia	edicai	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a					1-1			
_	ng phy es th	Ne de	resulting in death) Last	197	N							
Вох	leath certific attanding p	an/									1	
P.O.	tha c by the achex	Physician/M	Part II. Other significent conditions con	tributing to death but not resulti	ng in the ur	nderlying cause g	iven in Part I.		23b. Did to	~	ntribute 3 □ Pre	to the cause of death?
	uiras that signed l	2		- 11			-		24a. Was a	in autonsv	24b. V	Vere autopsy findings
of Vital Records,	aw 2 s	Completed						_	perfor	med?	a	vailable prior to completion of cause of death?
Œ.	ysician: The law i s certificata has b director, page 2 sl	E						- 4	124	35 2 XV	1	☐ Yes 2☐ No
/ita	ilc <b>lan</b> : The certificata rector, pag	Be	25. Was case referred to medical examiner?	a a - hali		10		of Death (Cl				
6		٩	TLI THE ZLANO	ospital: 1   Inpatient 2   EF		t 3LI DOA				ence 6 ⊡Oth ow injury occur		sify)
	ding P. After funer	E C	27. Menner of Déath  1 Natural 5 ☐ Pending investigation	28a. Dete of Injury (Month, Dey Year) 2	8b. Time of Injury	28c. Inju Wo M 1	ork? ]Yes 2∐		Describe ii	OW HIJERY GOODS	100	
Division	or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office	)	28f.	Location (S City or Tow	treet and Numb n, State)	beror <i>R</i> u	ral Route Number,
		edical Ce	29a. Certifier (Check only one)  (Check only one)	ictan: To the best of my knowle her: On the basis of examinetion end manner stated.	edge, death n end/or inv	occurred at the trestigation, in my	ime, date en opinion, dea	d place, end th occurred a	due to the o	ause(s) and ma late and place,	anner as and due	stated. to the cause(s)
	o the o the o the o the o	Med				29c. Licen	se number			29d. Date signe	d (Month	n, Day, Year)
	F≱Fö		Munic	MD		DOC	570	199		819	106.	
i.	10		30. Name end address of person who co	mpleted cause of death (Item 2) ALA, MD 1163	3e) (Type,	Print) errace	Drir	e Ste	103,1	Waldow	RP, N	1D 20603.
	Stat		31. Date filed (Month, Day, Year)	82. Registrar's Signatur	10 202				•			
	Registra		AUG T & SOMP	Selection St.	STATE	The state of the s						

			For	State of Marylan	d / Departmen		•	ne	
	-74		1 - State Registrar		Certificat	e of Death	Reg.	No.2006	25909
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Last Kathleen		organ		2. Date of Death Month July 2	Day Yeer 5 / 200 6	3. Time of Death
	Examin		4a. Facility Name (If not institution, give			Town, or Location of Dea	ath	4c. County of Death	h
				,,- 0 101	HOSPITAL	Takoma		trom	gamers.
	Funeral Director		5/9-54-2289	7. Age (In yrs. 64	Months	1 Year If Under 24 Hr Days Hours Mir	1. (Month, Day, Ye		ash., DC
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
	Mary I sh	to	Maryland Mont	gomery		Silver Sp	ring		1 XYes 2 No
	th the	Director	10e. Street and Number	,gomer y	10f. Zip			. Citizen of What Cou	untry?
	within 72 hours after death with the Maryland ene. Than "netural", or iteme 23a or 28a-f show ha Madical Exeminar must be multiled at		11616 Stewar	t Lane, #303		20904		United S	States
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was Dece	dent of Hispanic Origin? ( cify Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Amer Black, White	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify:	Negro
Maryland 21215-0036	2 hou	ted	15. Decedent's Edu	ucation	16a. Decedent's Usu		168	b. Kind of Business/I	industry
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT u	rk done during most of w se retired)	orking		
2	ifiled wi Hygien other th	Co		3	Ent	repreneur		Self-Emp	ployed
and	ntal H od ott	Be	17. Father's Name (First, Middle, Last) Ollie Mon	egan Cr		18. Mother's Na	ame (First, Middle, Mai		
<u> </u>	should be Ind Mental I	ဥ	19a. Informant's Name/Relationship (T		19b. Mailing Address	(Street and Number or F		Coleman	in Code)
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or iteme 23a or 28a-f show eny figury or other treumatic event, the Madical Examiner must be notified at once.		Sheran Reid/Nie						ng. MD 20906
Baltimore,	of Hearling		20a. Method of Disposition	20b. P	Place of Disposition (National Comments of	ne of		c. Location - City or 1	
E	Pages nent of I ant: if its ury or o		1 XBurial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Hemoval from State		emetery 8/	4/2006	Clinton,	, MD
a	Depermit. Depertm Importa eny inju		21. Signature of Funeral Service Licens	30eg)		nd Address of Facility	Stewart Fu		
	g Q E ≥ g		Jehn I.	Heward III		01 Benning			20019
			23a. Part 1. Finer the disease, or comp shock or heart failure. List only of			1			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Caula (Final disease or callion resulting in death)	a. Metasta		st cane			
	Examiner		f	Due to (or as a conseq	uence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a sonsoq	usnes of):				
	w requires that the death certificate be executed to be a signed by the ettending physicien and should be detached for use as the burial-transit	Examiner	that initiated events	c					
760,	cien a	EX	resulting in death) Last	Due to (or as a conseq	uence of):				
687	physicate to the the the the the the the the the the	dlcal		d					
×	Physician: The law requires that the death certifica this cartificate hes been signed by the ettending plaid director, page 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy			23d. Date of deli	ivery
Box	death e etter d for u	iciar	in the past 12 months?	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d				Month	Day Year
P.O.	the by the tache	hys	9 Unknown	9□ Unknown					
	es this igned be de	by F	Part II. Other significant conditions co	intributing to death but not res	ulting in the underlying o	ause given in Part I.		cco use contribute to	- 1
Records,	een s	ted	Congestive Hea	17 tailure			1 Tes	2 □ No 3 □ Pro 	obably 4 XUnknown
Sec.	e law hes b	npie	Diabetes to	JPC II	·		24a. Was an autopsy	prior to c	topsy findings available completion of cause of
교	r: Th		Hypertension		•		performed 1 ☐ Yes 2 D		2 🗆 No
5	siciar certif irecto	9 Be	25. Was-case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	150 mm = 150 mm	Other	eath (Check only one)		
ō	y Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 DC	28c. Injury at	Home 5 ☐ Residenc 28d. Describe how		cify)
Division of Vital	Attending r death. ector: After by the fune	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
N≥	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factor	y, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
0	urs efte rei Dir lied in								
	To the Hospital or Attending Physician: The lav within 24 hours effecteath. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	29a. Certifier  (Check only one)  12 Certifyin 1 Ph 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death occurred ation and/or investigation	at the time date and bla a, in my opinion, death oc	ce, and due to the cours curred at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of cartifies	SCA	29	c. License number	29d.	. Date signed (Month	n, Day, Year)
	1		·	SEANSS	AEDI MD	D-603	>59	7/26/01	6 (July 26)
R	(12)		30. Name and address of person who of New Har	completed cause of death (Item	n 23a) (Type, Print)	Classo.	no MD ?	20904. T	Dr. San
L			31. Date filed (Month, Day, Year)	MPShire AVE/)	ature # 500	1 Silver spri	3/10/1/2	-5 107,	5 Saedi
	Sta Regist		ALIC 0 2 2006	32. Registrar's Stude	Ander				

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State of Mary		artment of			giene Reg. No.2006	25911
- · · ·	Physici		1. Decedent's Name (First, Middle, Last) Sally M. Muckel		_			2. Date of Dea July 29		3. Time of Death 7:00 P <sub>M</sub>
	/Medic Examin		4a. Facility Name (If not institution, give s Anne Arundel Medi	cal Center		Anna	or Location of Dea		4c. County of Dea	undel
	Funeral Director		5. Social Security Number 201–34–9017 6. Sex Usual Residence of Decedent	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Yea Months Day			7, Year) 9. Bir 1943 Hun	thplace (State or Foreign buntry) tington, PA
	Maryland I-f show	tor	10a. State 10b. County Maryland Prince G		Bowie	ocation				10d. Inside City Limits 1   Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 2709 Babbitt La	ne		10f. Zip Code	20715		10g. Citizen of What Co USA	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show way injury or other traumatic event, I'm Medical Examinar must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Proproced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify: W.	te, etc.
21215-0036	d within 72 ho giene. ir than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	dent's Usual Occ kind of work don DO NOT use reti racts AC	ne during most of w red)	orking	16b. Kind of Business	Industry Contractor
Maryland	should be filed ind Mental Hygis marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Sydney King	10				ame (First, Middle, uerite Sl		
	and 2 sho ealth and n 27 is mu		19a. Informant's Name/Relationship (Ty, Cynthia Carter/ D	aughter	142	0 Harvey	Ave. Se	vern, MD	r, City or Town, State, 21144	
Baltimore,	Pages 1 ment of H lant: If Itel		20a. Method of Disposition  1 □ Burial 23X Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		Ob. Place of Dispo cometery, createry createry	natory or other p Tan Crer	matory 07/	Date 31/2006	20c. Location - City or Alexandria	
Ball	permit. Departr Imports eny injs		21. Signature of Funeral Service Licens	Pousll	6	512 NW (	Crain Hwy	eall Fune Bowie,	MD 20715	
	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence of):			eurys		Approximate Interval Between Onset and Death
8760,	icate be executed physicien and s the burial-transit	cai	resulting in death) Last	Due to (or as a cond.	nsequence of):					
P.O. Box 68	Physicien: The law requires that the death certificate be executed tribic certificate has been signed by the attending physicien and rail director, page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 grionths? 1 □ Yes 2 W No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnar ⊒ Other ( <i>specify)</i>			23d. Date of de Month	livery Day Year
	w requires that been signed t should be det	b	Part II. Other significant conditions con	ntributing to death but no	_	inderlying cause	given in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
Il Records,	sicien: The law re certificate has be irector, page 2 sho	Completed	alcohol a	buse				24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
Vital	sicien; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	- October		)than	eath Check only or		- 0 000 E
O	Afte fune	ation: To	1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier  28b. Time of Injury	of 28c. In	4 🗀 Nursing		lence 6 □Other (Spe ow injury occurred	cr(fy)
Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, offic	ce	28f. Location (5 City or Tow	Street and Number or R n, State)	ural Route Number,
	the Hospi in 24 hour the Funer pletely fill	Medical	(Check only 2 Medical Examination)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	vestigation, in m	y opinion, death oc	curred at the time, o	date and place, and du	o to the cause(s)
	To t com	×	29b. Signature and title of certifier    Jlanure   V		•	D	52830		July 30,7	1006
12	- (15)		30. Name and address of person who con Jeanine Werner, 31. Date filed (Month, Day, Year)  JUL 3 1 2006	mpleted cause of death MD 900 B	(Item 23a) (Type, 25 tgak	Print) Road #	-300 , A	nnapol	15, MD Z	.1401
28	Sta Regist		31. Date filed (Month, Day, Year)  JUL 3 1 2006	32. Registrar's S	Signature	B				

06-05360 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Fransisco Avelar Martinez 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 23, 2006 0325 hrs Medical Examiner Francisco Avelar Martinez 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Prince George's 9111 5th Street Lanham If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign E1 Salvador Months Days Hours Min Director 46 01/26/1960 1 X M 2 F none Usual Residence of Decedent 10c. City, Town or Location 10b County 10d Inside City Limits 1 X Yes 2 No or items 23a or 28a-f shomust be notified at once. Maryland P.G. Brentwood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? El Salvador 3406 40th Avenue Colmar Manor 20722 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes <u>or</u> Divorced If Yes, Give Year 1 X Yes 2 No specify Salvadoran White Widowed 4 Specify. Examiner "natural", 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene ant: If item 27 is marked other than "n or other traumatic event, the Medical E. MD 21215-0036 9th Carry out Chef 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francisco Avelar Candida Martinez Be 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $5448\ Tilden\ Road$ 19a. Informant's Name/Relationship (Type, Print ) Maria Luisa Martinez/sister 20710 Bladensburg, Maryland, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) permit. Pages
Department or
Important: I 08-02-2006 La Union, El Salvador Family Cemetery Donation 5 Other Specify 22 Name and Address of FacilityW.H. Bacon Funeral Home, Inc. Signature of Funeral Serv 3447 14th Street, N.W. Washington, D.C. 20010 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician 8etween Onset and /Medical Death a Stab wound to the neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit hysician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions <u>a</u> contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed of Vital Records, 24a Wasan 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one 25. Was case referred to medical Be Hospital: 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27 Manner of Death Certification: Subject stabbed FOUND: Natural 5 Pending 1 Yes 2 V No Jul 23, 2006 0324 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be State determined (Specify) Single Family 9111 5th Street, Lanham, MD 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the Hospital or Attending Physician: To the Funeral Director: Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 23, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Date filed (Month, Day, Year, State 2 8 2006 Ш Registrar **ORIGINAL** DHMH 17 Rev 1/2001 OCMF 2006

			1 - For State Registrar	State of	Marylar		artmen rtificat			and M	ental Hy	giene 2 (	106	259	13
	Physici /Medic		Decedent's Name (First, Middle, Last Olga Estella I								2. Date of De. Month July	Day	Year 2006	3. Time of D	
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	Funeral Director		5. Social Security Number 6. Se 583–68–1836 10 Usual Residence of Decedent	х ] м 2[ <b>X</b> F	7. Age (In yrs. 52	last birthday) Yrs.	Months Months	1 Year Days	If Under	Min.	8. Date of Bin (Month, Da Apr. 2.	y, Year) 3,1954	Cou	place (State or F ntry) 1., D.C.	oreign .
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	th with the		10e. Street and Number  2412 Belair Drive	9			10f. Zip		20715			10g. Citizen o	f What Cou USA	ntry?	
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-	Sta Registi		31. Date filed (Month, Day, Year)	2. R	egistrar's Sign	ature	11				9				

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	<sup>™</sup> #	2	Decedent's Name (First, Middle, La		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				2. Date of De	ath		3. Time of Death
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*	/Medic Examin		4a. Facility Name (If not institution, gir PRINCE GEORGES HOSF				4b. City, Town, o		ath		y of Death E GEORG	
2.71	Funeral			Sex	7. Age (In yrs	. last birthda	y) If Under 1 Year Months Days	If Under 24 H Hours Mi		th V Year	9. Birthpi Coun	lace (State or Foreign
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	pu *		Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or	Location				11	0d. Inside City Limits
	aho	5	MARYLAND MONTGOME	RY		ILVER S						1 ☐ Yes 2 ☑ No
	the N 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	stry?
	with la or	ă	436 NORTH WEST DRIV	E			20901				USA	, .
	ne 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in I	J.S. 13	B. Was Decedent of H	ispanic Origin?	(Specify Yes or No		ce - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Itama 23a or 28a-f ahow any injury or other traumatic event, Ita Medical Examinations invest be multiled at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fr 1 Tes If Yes, G Year or D	2 [XNo ive		If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	erto Rican, etc.)	Speci	rck, White, of the WE	etc. HITE
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Ma	d 2 sl th and th and 7 is r traur		EDWARD MARTIN - HUSE				NORTH WEST D				i, State, Zip	C008)
	Health Health tem 27		20a. Method of Disposition	MIND	20b.	Place of Dis	position (Name of		Date	20c. Location	- City or To	wn, State
5	Pages nent of H int: If it		14 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				rematory or other place L CEMETERY	· 1	3/2006	SUITLAN	D. MD	
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Ita		Bec	25. Was case referred to medical examiner?				1.750		Death (Check only			
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	5		30. Name and address of person who	completed cau	use of death (Ite	am 23a) (Typ	Do Dueen	(bun	Rd Hu	:115vi1	10 M	20781
	Sta Regist		31. Date filed (Month, Day, Year)  AUG 0.2 2	006	Registrar's Sig	nature	ali					
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			1 - State Registrar	State of Maryla	ind / Depa		of H	ealth ar	nd Me	ental Hyg	g. No. 🕹	006	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Elizabeth M. MacKe	nzie						2. Date of Deatl July 30		Year	3. Time of Death 6:15am M
	Examin		4a. Facility Name (If not institution, give st 8100 Connecticut A	reet and number) ave #316				Location of hase			Mon	ty of Death	ry
	Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In yi M 2∏F 95	rs. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth June 22	,1911	9. Birthp Top	lace (State or Foreign snam, ME
	Maryland f ehow	or	Usual Residence of Decedent           10a. State         10b. County           MD         Montgomer		City, Town or Lo							1	0d. Inside City Limits 1 📆 Yes 2 🗆 No
	or 28e-	Director	10e. Street and Number			10f. Zip (				10	Og. Citizen of	What Cour	ntry?
36	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other then "natural", or items 23a or 28e-f show reumatic event, the Mudical Examinar must be notified at	by Funeral	8100 Connecticut A  11. Marital Status  1 □ Never Married 2 □ Married  3½ Widowed 4 □ Divorced	.ve #316 2. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:				spanic Origi n, Mexican, Specify:	in? (Spec Puerto P	cify Yes or No- lican, etc.)		ice - Americ ack, White,	an Indian,
00-612	ithin 72 hou ne. "natura Mudical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual kind of work DO NOT use	k done d	uring most o	of workin	g	16b. Kind of	Business/In	dustry
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Mary	d 2 shouth and M 7 is mar treumat	_	19a. Informant's Name/Relationship (Type Jane Stevenson/Da	e, Print)		-				Route Number,		n, State, Zip	Code)
ore,	ges 1 en t of Heali if item 2		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ Re	20t	p. Place of Dispo cemetery, crei	sition (Nam matory or oth	e of her place	9)	Da	ate	20c. Location		
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,	6		30. Name and address of person who cor	mpleted cause of death (I	tem 23a) (Type,	Print)	D19					5.06	
			Raman R. Tuli, M.D.	10810 Dar	nestown	Rd,#2	202,	Gaith	ersb	urg,MD	20878		
. ₹ 3°	Sta Regista		31. Date filed (Month, Day, Year)  AUG 0 2 20	32 Pegistrar's Signature	B A	and I							

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arah Metz		1- For State	tate of Marylan	d / Depa	artment of	f Health ar		al Hygiene	2 2	006 259
Physicia	ın/	Registrar  1. Decedent's Name (First, Midd	lle,Last)				-	2. Date of De	eath	3 Time of Death
ledica] Examii	ner	Sarah Beth Me	etz					Month August 6	Day Yea 5, <b>2006</b>	1017 hrs
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Director		619-01-2667	1 M 2XF	27	• •	Months Da			5/1979	Foreign CA
		Usual Residence of Decedent								Odd/lity/ Cal
w any		. 10a State 10b. County		10c. City	, Town or Locat					10d Inside City Limits
Maryland 28a-f show o	ţ	MD Doro	chester		Hu	rlock				1 Yes 2 X No
te Mar or 28a	Director	119 Jackson St	reet			10f. Zip Code	1643		10g Citizen of Wh	,
with the 18 23a se noti	la	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13. Wa	1		? ( Specify Yes or N		- American Indian, Black,
death or item	Funeral	1 Never Married 2 X M	Armed Force	es? 2 <b>X</b> No	If Y	es, specify Cuba	in, Mexican, P	uerto Rican, etc.)	White	e, etc.
s after	by	3 Widowed 4 Dir	vorced If Yes, Give Year or Dates:			Yes 2 X N			Specify	White
2 hour "natu	eted	15. Decedent's Education (Spe Elementary/Secondary (0-12)				t's Usual Occupa ost of working life			16b. Kind of Bu	siness/Industry
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2121 uld be fi Mental I marked c event,	Be	Roger L. Jones						L. Rayner		
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re, MC s I and 2 s of Health ar If item 27		Roger A. Metz/ 20a. Method of Disposition			Place of Dispos	Jackson tion (Name of ce	Street emetery,	Date Date	20c Location -	643 City or Town, State
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Baltimore, permit Pages I ar Department of He Important: If ite	Ì	21. Signature of Funeral Service			22. N	ame and Addres	s of Facility	2006	<del>_</del>	<del></del>
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Physician /Medical		23a. Part I Enter the disease, or failure. List only one cause	on each line.		. Do not enter th	e mode of dying	, such as card	liac or respiratory ar	rest, shock, or hea	Approximate Interval Between Onset and
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Box 6  death cer the attendi	sicia	past 12 months?  1 Yes 2 No 9 ✓ Uni		at time of de	ath _	ner (Specify)		ognanoy	Wichter	Day Teal
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ds, require	Completed		-					24a. Was		/ere autopsy findings available
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II R		25. Was case referred to medica	<u> </u>			26 Place	e of Death (Ch	1 Yes	2 No 1	Yes 2 No
Vital y sician: this certifi	To Be	examiner?	Hospital: 1 Inpa	tient 2	ER/Outpatient		Other -	ursing Home 5	Residence 6	Other
n of Vi	آڃَ	27 Manner of Death	28a. Date of Ir (Month, Day	njury (,Year)	28b Time of Ir		ry at Work?	1	how injury occurre	d
ivisior or Attend after death Director:	ăti	Natural 5 Pend 2 Accident Invest	stigation FIR 6/0/		Fnd 9:18	J Call	Yes 2 X No	uik		
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hou hou		4 Homicide	hysician: To the best of		utside reg		oto and slass	inurlock,		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 ✓ Medical Exa	miner: On the basis of ex	kamination ar	nd/or investigati	on, in my opinior	ate and place	and due to the cause red at the time, date	se(s) and manner a and place, and du	as started e to the cause(s)
F 3 F 8	ĕ	29b Signature and title of certifie				29c. Licens	se number		29d. Date signed	(Month, Day, Year)
		ande	Hall	an		O.C.	M.E.		August 7, 20	006
	İ	30 Name and address of person							·	
		Carol Allan, MD As: 31. Date filed (Month, Day, Year)	sistant Medical Exa	aminer rar's Signatu		treet, Baltim	ore, MD 2	1201		
Sta Registr	_	AUG 11		. Gr G Gigilalu	Alaga	of n				

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 29,2006 4:44p M July Oma Faye Mecke 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) E1kton | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | July 30,11932 Cecil Union Hospital 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Chester, PA 1 ☐ M 2 💢 F 73 533-40-1612 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Cecil E1kton 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21921 662 Augustine Herman Hwy. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3€ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sears Warehouse Supervisor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Geneva Simpson Bane Cheek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20137 16605 Gaines Rd., Broad Run, VA Rebecca Ledford/Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State August 2, Zion Cemetery Peach Bottom, 4 ☐ Donation 5 ☐ Other (Specify) 2006 21 Signature Fuller Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or fleart failure. List only one cause on each line. E1kton, MD 21921 Approximate Interval Between Onset and Death Immediate Cause (Finaf Due to (or as a consequence of). crest disease or condition resulting in death) Due to (1) consequence of): Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury ble that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

: if item 27 is marked other then "neturel", or items 23s or 28s-4 show or other traumstic event, the Modical Examinar mast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or item any injury or other traumatic event, Its Mandal

Baltimore, Maryland 21215-0036

death with the Maryland

use as the burial-transit led by the attending physician and detached for use as the burial-trar After this certificate has been signed by funeral director, page 2 should be detac

Physician: The law requires that the death certificate be executed

Hospital or Attending

å

death.

within 24 hours after deatl To the Funeral Director; filled in by the

completely

Division of Vital Records, P.O. Box 68760

Examiner

by Physician/Medical

Be Completed

Certification: To

Medicai

IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 DNo 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Dectopic pregnancy 5 Other (specify)
Part If. Other significant condition	ns contributing to death but not resulting in	the underlying cause given in Pa

23d Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Was an

Year

autopsy 1 Yes 2

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only or Other: 4

☐ Nursing Ho	ome	5 Residence	6 ☐Other (Specify)
	28d.	Describe how infl	ury occurred

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 □ Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 Inpatient

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Naturaf 2 Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number 700000725

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month. Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223 W Main St. Elkton, MD.

State Registrar

31. Date fifed (Month, Day, Year)

2 2006 AUG

oksoygon, MD

DHMH 17 Rev 1/2001

2 ER/Outpatient 3 DOA

28b. Time of

			For	State of Marylan	d / Departmer	nt of Health and M	lental Hygiene	9 0 0 0 0	m ~
_			State Registrar		Certifica	te of Death	Reg. No	2006	25918
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last)  DOTOTHY  4a. Facility Name (If not institution, give stre	izabeth eet and number)	Matt.	hews , Town, or Location of Death	2. Date of Death Month Da		3. Time of Death 00 42 M
7813	Funeral Director	e.	Feninsula legional 5. Social Security Number  228-44-7813  Usuel Residence of Decedent	Medical C. 7. Age (In yrs. 69	last birthday) If Under Months	Ti Year I Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year	) Count	ace (State or Foreign
- Ah 82	with the Maryland a or 28a-f show the notified at	Director	10a. State 10b. County  Morce S  10e. Street and Number	10c. Cit	ty, Town or Location	ip Code	10g. C	itizen of What Count	od. Inside City Limits  1 XYes 2 □ No  1 Yes 2 □ No
2 2	ter deeth Items 23	Funerai	501 Maple S+1  11. Marital Status  1 Never Married 2 Married	Was Decedent Eler in U Armed Forces? 1   Yes 2 igNo If Yes, Give	40/ 2 I.S. 13. Was Dece If Yes, spi	adent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
1215-0036	within 72 hours ene. than "natural", ne Modical Ext	Completed by	3 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Year or Dates: tion completed) College (1-4or 5+)	life. DO NOT	rork done during most of work use retired)		Cind of Business/Ind	ustry
We Dorothy	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Mental Mental Control of the Mental Control of	To Be Co	17. Father's Name (First, Middle, Last) Willie Flo	Werr		Virginia	e (First, Middle, Maide	vis	ms ruyl,
	s 1 and 2 sho f Health and I from 27 is m		19a. Informant's Name/Relationship (Type Patricia Conawa 20a. Method of Disposition	y (daughter	19b. Mailing Address Place of Disposition (Nacemetery, crematory or	ss (Street and Number or Rur ame of other place)	Pocomo	or Town, State, Zip	nd.2185
Matthe	permit. Pages Department of Important: If I any Injury or once.		1 X Burial 2 Cremation 3 Rer 4 Dopartien 5 Other (Specify) 21. Signal re of uneral Service Licensee	noval from State	ow Hill Del	and Address of Facility Be	2-06 SN	ow Hill	md cool Home
	Physician		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the deal cause on each line.	th. Do not enter the mo		or respiratory arrest,	12 21497	Approximate Interval Between Onset and Death
. 0220		dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consecutive to (or according to	s Mell	Litus			
9	Attending Physician: The law requires that the death certificat death.  cleath. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3 ☐Ectopic			23d. Date of delive Month	ry Day Year
9	INISION OF VITAL INCOURS, F.C. BOX for Attending Physician: The law requires that the death cert after death.  Director: After this certificete has been signed by the attendin in by the funeral director, page 2 should be detached for use	ted by Ph	Part II. Other significant conditions control  Skyn Negos/	•	sulting in the underlying	g cause given in Part I.		use contribute to the	e cause of death? ably 4 □Unknown
0	VII.d. neck ician; The law r certilicete has be ector. page 2 sh		25. Was case referred to medical			26 Place of Dea	24a. Was an autopsy performed?  1 Yes 2 N	prior to cor death?	psy findings available inpletion of cause of
*****	ysician: ysician: nis certific i director.	To Be	avaminer?	spital: 1 (Propatient 2	☐ER/Outpatient 3☐ I	DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify	)
!	ding Ph		27. Manner of Death  12Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fact		28f. Location (Street: City or Town, Sta		l Route Number,
	Hospi 24 hour Funer stely fill	Medical	(Check out) O Medical Evamin	er. On the bacic of examin	ation and/or invactigation	ed at the time, date and place on, in my opinion, death occu	rrad at the time, date a	nd place, and due to	the cause/s)
	To the within To the	Me	29b. Signature and title of certifier	•	2	29c. License number	29d. C	Date signed (Month,	Day, Year)
			/aul 1-Fle	ly MD	om 23a) (Tupo Brint)	004812	8	11/04	
	BAZ		30. Name and address of person who com	curry ME	0 303	- Tenth S	T Pac	omoke	City MD
	St Regis	ate trar	31. Date filed (Month, Day, Year) AUG 0 3 200	32. legistrar's Sign	hally Aparle	29c. License number 024872 5 Tenth S			•

	For State	• •	laryland / Depa		Health and	Mental Hyg	iene eg. No.2 0 0 6	25919
4	Registrar  1. Decedent's Name (First, Mic	idle. Last)				2. Date of Deat	th	3. Time of Death
Physician			26111			August	8, 2006	10:55 p.M.
/Medical	Gertrude  4a. Facility Name (If not institu	Bertram	Miller	4h City Town	or Location of Deat		4c. County of Deal	
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	St. Mary's Nu		ge (In yrs. last birthday)					
Funeral	,	6. Sex 7. A	Vrc	Months Days		(Month, Day		tholace (State or Foreign buntry)
Director	177-03-9327		91			Sept.11,	1914 New	York
p	Usual Residence of Decedent  10a. State 10b. Cour	ntv	10c. City, Town or L	ocation				10d. Inside City Limits
ehow				0.116				1 ☐ Yes 2 X No
d 21215-0036 filed within 72 hours atter death with the Maryland Hygiene. then "natural", or iteme 23a or 28e-f ehow ont, the Modelal Examinat must be notified at a Completed by Funeral Director		Mary's		Californ	11a		log, Citizen of What Co	ounter?
or 2	10e. Street and Number						rog. Onizer of What O	rainty :
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State death verifier death verifiere 23state and intercount	11. Marital Status	12. Was Deceden Armed Forces		Was Decedent of if Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
F. Brit	1 Never Married 2 N	If Yes Give	]No	1 ☐ Yes 2 <b>X</b> No	o Specify:		Specify: W	Thite
21215-0036 within 72 hours att giene. In then "natural", or then "natural", or the Model Extend	3X Widowed 4 □ Divore	ced Year or Dates						
21215-00 ad within 72 hou vgiene. Than "natura t, the Model	15. Deced (Specify only hig	dent's Education thest grade completed)	(Give	edent's Usual Occu wind of work done	e during most of wo	erking	16b. Kind of Business	Industry
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212 d with giene.		2		Bookkeep			Public Sc	hools
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/lan/ uld be Wenta Wenta in the et a trice e	Francis Bert	ram			Donn	a Navy		
Maryland d 2 should be file th and Mental Hy it is marked oth traumatic event To Be (	19a. Informant's Name/Relati	onship (Type, Print)	19b. Mail	ing Address (Stree	et and Number or R	ural Route Numbe	r, City or Town, State,	Zip Code)
Ma dd 2 g7 is trau	Grace B. Hil	der / Sister	23140	) Cobbles	stone Lan	e. Califo	rnia, Mary	land 20619
Baltimore, M permit Pages 1 and 2 Department of Health Important: If frem 27 any injury or other tre	20a. Method of Disposition	del / biscer	20b. Place of Disp	osition (Name of		Date	20c. Location - City or	Town, State
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Baltimore, semit. Pages 1 a bearing 1 feet and 2 bearing of the mportant: If feet my injury or otherans.	4 □ Donation 5 □ Othe						Charlotte H	
Balt permit. Departr Importa	21. Signature of Funeral Serv	Short !					Funeral Ho	
m «q==a	Edward N. Bri	nsfield, Jr.	M00052 22	2955 Holl	Lywood Ro	ad, Leona	ardtown, MI	20650-0279
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Physician	Immediate Cause (Final		Raining	Paris	Failus	0.		Onset and Death
/Medical	disease or condition resulting in death)	a	as consequence of):	no oy 1	unu.		-	(cecies)
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Box eath cert attending for use	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnan	nov		23d. Date of de	*
Death death of for	in the past 12 months?	4☐Pregnant	at time of death 5	Other (specify)			Month	Day Year
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ds, signe d be o	+	Tunan La	nsum)			1 🗆 Y	'es 2፟፟፟No 3☐F	Probably 4 Unknown
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law las to 2 sl		LO HARRY	yvocasy	m		24a. Was autop	an 246. Were a esy prior to rmed? death?	utopsy findings available completion of cause of
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of Vital Rec Physician: The lav this certificate has ral director, page 2 : To Be Compi	25. Was case referred to me-	dical	4-41		26 Place of De	eath   Check only o	ne)	
ysicii s cer direct	examiner? 1 🗌 Yes 2 🙋 No	Hospital: 1   Inpa	atient 2 Outpatio	ent 3 DOA	ther: 4 Nursing	Home 5 Resid	dence 6 □Other (Sp	ecify)
Of physical three seral dis	27. Manner of Death	28a. Date of h	njury 28b. Time Day Year) Injury	of 28c. In	jury at	28d. Describe h	now injury occurred	
on on on the state of the state	1   Natural 5 □ Pe 2 □ Accident inv	nding (World), i	Day 16a1) Injury		Yes 2 No			
or Attending or Attending ther death. Director: Atte in by the fune	3 ☐ Suicide 6 ☐ Co	uld not be 28e. Place of	Injury - At home, farm, s	street, factory, offic	:e		Street and Number or F	Rural Route Number,
Division of Vital Records, tall or Attending Physician: The law requires the state death is practice; After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	4 Homicide	building,	etc. (Specify)			City or Tox	vn, State)	
- is simple O		ifying Physician: To the be	et of my knowledge, de	ath occurred at the	time, date and play	ce, and due to the	cause(s) and manner	as stated
thin 24 house the Fune mpletely fill	29a. Certifier 1 Cert	ical Examiner: On the basis	of examination and/or					
Aed nple	one)	and manner	Stated.	29c Lice	anse number		29d. Date signed (Mor	ith Day Year)
S T Will T	29b. Signature and title of ce	runer	1 - 11	1	0////	Q.	09	2/
	l la	MAIT. Va	NOEIVE	MU	0041		0-1-6	10
	30. Name and address of per	son who completed se se o	of death (Item 23a) (Type	e, Print)				
	James P.//Jar	boe, M.D., 24	4035 Three	Notch Roa	ad, Holly	wood, Man	ryland 2063	36
State	31. Date filed (Month Day )	(ear) 1 2005 12 eg	strar's Signature	1	•			
Registrar	WOR	T T COOD	A TO WAY					

			. For	State of Mary				-	iene	A. W. W. W. W. W.
			1 - State Registrar		Cer	tificate of	Death	R	eg. Nov. UU 6	25920
	/ /		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Yeer	3. Time of Death
	Physicia /Medic		Rose M. Ma	hon					2006	5:00P M
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	or Location of Death		4c. County of Death	1
			Northampton Mano			Frede			Frederi	
	Funeral		5. Social Security Number 6. Sex	7. Age (Ir	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birth 25, 1908 M	pplace (State or Foreign untry)
н	Director		214-05-3228 Usual Residence of Decedent	90	113.			March 2	25, 1908 M	aryland
3	ow #		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	in the	ğ	Maryland Frederic	k	Ijamsv	ille				1 ☐ Yes 2 🗷 No
1	r 289	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
1	ueatr with the maryland ms 23s or 28s-f show rount be notified at	aiD	11345 Windsor Ro	ad		21	754		U.S.A.	
	80	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13. \	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
9	or it		1 Never Married 2 Married	1 ∐ Yes 2 ŽŠNo If Yes Give		1 ☐ Yes 2 X No			Specify: IN	/
3	filed within /z hours arief Hygiene. Ither than "natural", or ite ent, the Musical Expudine	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	16a Danas	dent's Usual Occup	nation	-	V-	
င်	"nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of work d)	ing	16b. Kind of Business/l	ndustry
7	than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)		erical W			Montgomery	Ward
ם כ	Hyg other	BeC	17. Father's Name (First, Middle, Last)			CIICAI W	18. Mother's Nam			
al	ould be Mental arked o	To B	Julius E. Go	ttscha1k			Liz	zi M.	Boyle	
Maryland 21215-0036	s should be lined within 7.2 hours arien dearn with the marylan and Mential Hygiene. and Mential Hygiene. is marked other than "natural", or items 23a or 28a-f show sumatic event, the Markical Examiner mant be notified at		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Number	, City or Town, State, 2	ip Code)21754
Σ	alth a		Nancy R. Leftwich	- Daughter	: 11	345 Winds			ille, Mary	Land
e .	permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is marked any injury or other traumatic syppe.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R		20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	ce)		20c. Location - City or	Town, State
Ĕ,	Fages nent of I		4 Donation 5 Other (Specify)	emovar nom State	Meadowri	dge Ceme	tery 8-4	1-06	Elkridge,	Maryland
Baltimore,	Departi Departi Importi any inj		21. Signature of Funeral Service License			. Name and Addre		. D Λ = 1		
	2011		Tovert L. N.	Muns	26	5401 Ride	e Road,	Damascu	Funeral Horas, Maryland	
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the re cause on each line.	death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition	A/21	leiner	is Der	nentia			419rs
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					1
	-xammer	L.	Sequentially list conditions,	). Due to (or as a co	ineconomie v offi					
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsoquence on.					
	al-trar	xar	that initiated events cresulting in death) Last	Due to (or as a co	onsequence of):					
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Вох	nding use a	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p		7e			23d. Date of deli	very
m j	deatr e ette d for	Cia	in the past 12 months?	1□Live birth 2□ 4□Pregnant at tim		]Ectopic pregnanc ] Other (specify) _	у		Month	Day Year
P.O.	trine by th tache	hys	9 🗆 Unknown	9□ Unknown				-		
'n.	The law requires that the death certilical site has been signed by the ettending phy page 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tol	bacco use contribute lo	the cause of death?
ğ	w require been si should t							1 🗆 Yı	es 2 No 3 Pro	obably 4 □Unknown
မ	as be	Completed						24a. Was a autops		topsy findings available completion of cause of
Œ,	The ete h page	E O						perfor	ned? death?	2□ No
Ħ.	artific ctor,	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th Check only on	(0)	
<u> </u>	hysic this co	ို	1 ☐ Yes 25 Ne		2 ER/Outpatier	IT 3 DOA			ence 6 □Other (Spec	cify)
ב	After 1	on:	27. Manner of Teath  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	Wo	rk?	28d. Describe ha	ow injury occurred	
Division of Vital Records,	tend leath tor: /	Certification;	2 Accident investigation 3 Suicide 6 Could not be	One Diese of leive	At home form at		]Yes 2 □No	20f Location (C	treat and Number of Ci	To the Market
$\leq$	after d Direct Jin by	E E	4 Homicide determined	28e. Place of Injury building, etc. (3	- At nome, farm, str Specify)	eet, factory, office		City or Town	treet and Number or Ru n, State)	rai Houte Number,
_	To the Hospitel or Attending Physicien: The law within 24 burus after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phys	sician: To the best of m	v knowledge death	h occurred at the ti	me date and place	and due to the c	ause(s) and manner as	ctated
:	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examinations)	ner: On the basis of ex and manner stated	amination and/or in	vestigation, in my	opinion, death occui	rred at the time, d	ause(s) and manner as ate and place, and due	to the cause(s)
	ithin o the omple	Me	29b. Signature and title of certifier	-		29c. Licen	se number	2	9d. Date signed (Monti	n, Day, Year)
!	- s ⊢ ō		Vin Ok	1/ 12/		) 3	31058		8-1-06	
	10		30. Name and address of person who co	empleted cause of deat	h (Item 23a) (Type,	Print)		ļ	- 1 - 0	
	V		Gene Ashe, M.D.		oppermine		Woodsbord	, Maryla	and 21798	
	Sta		31. Date filed (Month, Pay Year) 3 2	005 32. Projistrar's	Signature	back				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 006 July 31, **Physician**  $1:25^{\circ}$ Frances Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Garrett County Memorial Hospital Oakland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/24/1936 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Mary land 1□M 2 F Days 234-62-4264 Director 69 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28e-f show item 27 is marked other then "netural", or items 23a or 28e-f shov other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Oakland MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21550 400 Glade Square #5 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a nand Mental Hygiene. Is marked other then "netural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nursing Home Nurses Aide 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Cline Michaels .Iohn Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treun Rt 5 Box 26 Keyser, WV 26726 Rick Mallow/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/3/06 Maysville, WV Mt. Hebron Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service ( 22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) BREAST Physician ANCER /Medical Due to (or as a consequence of) **Examiner** Metastas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an filled in by the funeral director, page 2 autopsy performed 3 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 | Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Xu 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) S 1 1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 RUTH C. MARSHALL July 3:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cilv. Town, or Location of Death Examiner Talbot Genesis HealthCare -The Pines Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔏 F Months Days Director 219-14-3109 FEB 20, 1925 MARYLAND 8 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itsm 27 is marked other than "neturel", or Items 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director TALBOT **EASTON** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 610 DUTCHMANS LANE death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 ▼Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) LAUNDRY, DRY CLEANING 0 INVENTORY CLERK 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental EVELYN S. SHERWOOD WALTER R. CARROLL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If itsm 27 is any injury or other tra H. STANDLY CARROLL/BROTHER 29212 WOODBRIDGE DRIVE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 8/1/2006 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardio my goethy Physician MERNS /Medical **Examiner** \$50A/S S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner use as the burial-transit rend amic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 2 No To the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 XNo 2 2 ER/Outpatient 3 DOA 4 Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) ter death. irector: After this irector by the funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 (ROWLE) 31. Date filed (Month, Day, Year) JUL 3 1 2005 Registrar's Signature State Registrar

			For State Registrar	State of Mary		artment of F rtificate of			giene Reg. No 200	6 25923
k		15	1. Decedent's Name (First, Middle, Las	t)				2. Date of De. Month		3. Time of Death
	Physici /Medic	_	Clyde	Moore,Sr.					UST 1 20	2120M
	Examin		4a. Facility Name (If not institution, give	street and number)	(	4b. City, Town, o	r Location of Death	, ,	4c. County of E	Death
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	Funeral Director		5. Social Security Number 6. S	2 M 2□F 69	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da	y, Year)	Birthplace (State or Foreign Country) irginia
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	death with the Maryland ms 23a or 28a-f show I IIIwat Le i cilling at		10a. State 10b. County	10	oc. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma	cto	Maryland Carol	ine	Dentor	1				1  Yes 2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	s 23s	rai	604 Riverview G		-1-110		629		USA	American Indian,
	ter de	nu	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Eve	or in U.S. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Black, V	Vhite, etc.
336	al', or	by	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	Black
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Maryland	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic								,Maryland	
	s 1 and of Health Item 27 other tr		<u>Iris Moore</u> , Wife 20a. Method of Disposition		20b. Place of Dispo	osition (Name of		Deliton	20c. Location - City	
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Baltimore,	permit. Pages 1 Department of H Importent: If Itel sny injury or ott		21. Signature of Funeral Service Licen			Name and Address BEnnie S				ile, Hary Land
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		1	For State Registrar	State of Maryland	d / Depa	artment c			ental Hygi	ene 0	0.6	25924
Ž.		7	Decedent's Name (First, Middle, Last,	)				2	2. Date of Death Month		Vone	3. Time of Death
	Physicia	_	NOAH CARR	OLL NEW					JUL	25 26	006	9:45 P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tov	m, or Location o	of Death		4c. Count	y of Death	
*	Lxamin	C1	NATIONAL NAVAL	MEDICAL CENTER	}	I	BETHESDA	1		MONTGOMERY		
	Funeral '		5. Social Security Number 6. Se			If Under 1 Y			B. Date of Birth (Month, Day,	Vearl	9. Birthp	lace (State or Foreign try)
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Þ	be filed within 72 hours after death with the Maryland by they given by the market is the market by	Be (	17. Father's Name (First, Middle, Last)						(First, Middle, M		me)	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: if item 27 is marked other than "natural; or tiems 23a or 28a-f show any injury or other traumatic event, the Mudical Examinat must be notified at angre.		19a. Informant's Name/Relationship (T	vpe, Print)	19b. Maili	ng Address (S	treet and Numbe	er or Rural	Route Number,	City or Town		
Σ	alth alth		Jo Ann Cooper Kil	Leen (friend)			alie Joy		e, McLea	an, VA		01-5635
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×	the death certifica y the attending ph iched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ncy	11				23d. D	ate of delive	эгу
Вох	atter 1 for	clai	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		⊒Ectopic pregi ⊒ Other (speci				N	lonth	Day Year
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	that ed b deta		Part II. Other significant conditions co	ntributing to death but not res	ulting in the i	underlying caus	se given in Part I	1.	23e. Did tob	acco use co	ntribute to t	ne cause of death?
Vital Records,	uires sign	d by							1 □ Ye	s 2X No	3 🗌 Prot	bably 4 Unknown
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<u>=</u>										Z No	1 🗌 Yes	2 No
Ξ	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:	<b>50.0</b> · · ·		Other		(Check only on			
ot	Phys this ral di	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	ER/Outpatie 28b. Time		Injury at		sd. Describe ho			y)
n	ing After une	lo n	1 XNatural 5 ☐ Pending	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐			, , ,		
Si	at par	cal	3 Suicide 6 Could not be		ome farm s				8f. Location (St	reet and Nun	nber or Run	al Route Number,
Division	if or Attending after death. I Director: Afte d in by the fune	Certification;	4 Homicide determined	building, etc. (Specif		11001, 1401019, 0			City or Town			
	Hospital 14 hours a Funeral tely filled		29a. Certifier 1 X Certifying Ph	ysician: To the best of my kno	wledge dea	th occurred at	the time date ar	nd place, a	nd due to the ca	ause(s) and r	nanner as s	tated
	Hos 24 hc Fun stely	Medical		iner: On the basis of examina and manner stated.								
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by ti	Me	29b. Signature and title of certifier			29c. L	icense number		2	9d. Date sign	ned (Month,	Day, Year)
	E 3 E 3		20 1/	•	0	01	01239146	6 (VA	)	27	iv.	- ob
1	(~)		30. Name and address of person who	completed cause of death (Iter								
1	110/				Luar (Type	, ( 1111)			AL NAVA DA MD 2			ENIEK
	1. SEE C.	ate	S.R.RAMCHANDANI 31. Date filed (Month, Day, Year)	Denistraria Ciana	ature 🥒			ETUES.	UM PIU Z	0003-3	000	
	Regist		JUL 3 1 2000	Place &	Apo	de la						

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iary Nix		-For State of Maryland / Department of Health and Mental H	ygierie Reg. 1	20	06 2592
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	Date of Death     Month Da		3. Time of Death
Medical Examir		Mary Nix  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	July 21, 2006	4c. County of Dea	0754 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death Prince Georges Hospital Center  Cheverly		Prince Georg	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		/M/DD/YYYY) 9. B	
Director		260-46-1566 1 M 2XF 76 Yrs. Months Days Hours Min	10/12/1	.929 Fore	o'Gteorgia
any	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<b>*</b>		Maryland Prince George's Hyattsville			1 Yes 2 No
ne Maryland or 28a-f show fied at once	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?
the M 3a or 2		3708 Warner Road 20784			States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be nedfied at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 11. Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (S		14. Race - Ame White, etc.	erican Indian, Black,
ter dez ", or i		X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	Black
ours a	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		b. Kind of Busines	s/Industry
36 n 72 h nan "n lical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+)			_
-00. d with giene ther the	mo;	12th         Sales Clerk           17. Father's Name (First, Middle, Last)         18.Mother's Name	e (First, Middle, Maid	den Surname)	P <u>rivate</u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	æ	Levi Nix	Hattie M	lae Sheri	dan
D 21 should and Me	٤	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or		•	
MD and 2 sho lealth and tem 27 is traumati		Rufus Nix/Brother 510 Halifax Place.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	0c. Location - City	MD 20//4 or Town, State
nore ages 1 nt of F nt: If i		1 X Burial 2 Cremation 3 Removal from State crematory or other place) Park 4 Donation 5 Other Specify: A Maryland National Mem. 7/	31/2006	Taural	MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		700	Stewart Fu		
		23a. Par II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	. NE Wa	sh. DC	20019 Approximate Interval
Physician /Medical		faill 9. List only one cause on each line.	or respiratory arrest,	SHOCK, OF HEAR	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			+
		Sequentially list conditions, b.			
	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated			4
ted Insit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.			1
Division of Vital Records, P.O. Box 68760, within 124 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED			
760, icate be physical the buri		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delive	
Box 687  E death certific  the attending p	cian	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	laricy	Month	Day Year
charthe death certification bed by the attending petached for use as the	Physician/	1 Yes 2 ✓ No 9 Unknown g Unknown	220 Did tobo	ana una captributa	to the cause of death?
Division of Vital Records, P.O. Is a or Attending Physician: The law requires that the late feath.  Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			robably 4 Unknown
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e law re has be ge 2 sh	ldw		autopsy performe 1 ✔ Yes 2	ed? death	?
al Re in: The ertifical tor, pa	Be Co	25. Was case referred to medical 26.Place of Death (Check			
Vita hysicia this ca	To B	1 V Yes 2 No		sidence 6 Oth	ner:
n of ding P a. After funers		27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe hov	v injury occurred	
isio Atten r death rector: by the	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stre	eet and Number or	Rural Route Number, City
Div ital or urs afte ral Dir	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Stat	e)	
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deter		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause(s	s) and manner as st	arted.
To th withir To th	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier  29c. License number		9d. Date signed (A	
	2	O.C.M.E.		July 22, 2006	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		30. Name and ad ress of person who om leted cause of death (Item 23a)			
(142)		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
S Regis	tate	31. Date filed (Month, Day, Year)  Registrar's Signeture			

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Maryland 21215-0036 nd 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. It is marked other than "natural", or terms 23s or 28s-1 show that manife event its Medical Experient to promise the property.
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permit. Pages 1 and Department of Health Important: If item 27 any injury or othar ti once. Baltimore Priysician /Medical

JANE NEWCOMB

Examiner burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Box 68760 ig. ö P.O. of Vital Records, page 2 s director, Division death. 24 hours after death e Funeral Director: in by filled

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** JANE SAUNDERS NEWCOMB JULY 28 2006 8:45AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 225 WYE AVE. TALBOT EASTON 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days Hours 1 □ M 2**X**) F Yrs. 59 218-48-6799 1946 **MARYLAND** Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Director TALBOT EASTON 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 WYE AVE. 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 X Married 1 Yes 2 No ģ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 ARTIST WEARABLE ART 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES NELSON SAUNDERS GERALDINE BRENNEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEVIN J. NEWCOMB III/HUSBAND 225 WYE AVE., EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 7/31/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA NOHN **R**. MERCERON 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 16 disease or condition resulting in death) sear (or as a consequence of): Sequentially list conditions, if any, is a large to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X esidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0053602 30. Name and address of son who completed cause death (Item 23a) (Type, Print) CAROLYN HELMLY M.D., 508 IDLEWILD AVE., EASTON, MD 21601 31. Date filed (Month, Day, Year) State AUG 0 1 2006

Registrar

completely

within 2 To the To the

		1	For State Registrar	State of	Marylan		artment o				giene Reg. No. 2	006	25927
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Fune	ral		5. Social Security Number 6. 5	Sex 1 □ M 2 🕱 F	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birt (Month, Day May 23,	h y Year)	Cou	olace (State or Foreign ntry)
Direc	tor	-	220-01-7216 Usual Residence of Decedent		87	Yrs.			ļ. ļ.	May 23,	1919	New	York
yland sow	4	-	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
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ith th	2	Directo	10e. Street and Number				10f. Zip Cod	e				n of What Cou	ntry?
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fterd		E L	1 Never Married 2 Married	Armed For	ces? 2 🙀 No	1	Was Decedent If Yes, specify 0			Rican, etc.)		Black, White	
2-UUSO 72 hours after natural, or ite	2.00	<u>م</u>	3	If Yes, Give Year or Da	9		1□Yes 2Å	No Specify	/: 		S	pecify: Whi	te
72 hours	2015	Completed	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usual Oc kind of work do DO NOT use re	cupation ne during mos	st of workin	ng	16b. Kind	of Business/fr	dustry
filed within Hygiene.	28 M	dmo	Elementary/Secondary (0-12)	College (1-	4or 5+)	House		ineu)			Home	emaker	
a filed Hygin	, L	Be C	17. Father's Name (First, Middle, Las	r)		110000		18. Moth	er's Name	(First, Middle,	Maiden Su	ımame)	
Zaryiana Z IZ 2 should be filed withir and Mental Hygiene. Is marked other then		2 2	Thomas Thompson	<u> </u>				Eliz	abeth	Becker	•		
2 sho	Ĕ	9	19a. Informant's Name/Relationship				ng Address <i>(Str</i> Bay Str						o Code)
e, IV 1 and Health em 27	1001	-	Kenneth Nichols/C		20b. F	Place of Dispo	sition (Name o	, ,		ate		tion - City or T	own, State
ages ant of ht: If It	y or o		1 ☐ Burial 2 📆 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		State Sa.	Tisbury	y Crema	LOLY	08/03	1/06		-	aryland
Dantimore, Ma permit. Pages 1 and 2 Department of Health a Important: If New 27 Id	nlu si	1	21 Signature of Funeral Service lice			22	Name and AdolloVay	Idress of Facil	iga Ho	me P.A.			
<b>a a a a</b>	2 3		John / fall	160		5	01 Snow	Hill	Rd. S	alisbu	cy,Ma	cyland	21804
	ella Ja		29a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that ca one cause on ea	ius e deat ich line	th. Do not ent	er the mode of	dying such as	s cardiac of	/ /			Approximate Interval Between Onset and Death
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DOX attending	e co	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnant		∃Ectopic pregna	nov			230	d. Date of deliv	
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DIVISION  or Attending after death.  Director: After	oy the	E Ca	3 Suicide 6 Could not l	e 28e. Place	of Injury - At h	ome, farm, sti	reet, factory, off					Number or Rur	al Route Number,
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DIVISION To the Hospital or Attending within 24 hours after death. To the Furneral Director: After	≣ ∤	<u></u>	(Check only 2 Madical Exa	hysician: To the miner: On the ba	sis of examina	owledge, deat ation and/or in	h occurred at the	e time, date a ny opinion, de	ind place, a ath occurre	and due to the	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
o the	mplet	Medic	one) 29b. Signature and title of certifier	and marin	er stated.		29c. Lic	ense number			29d. Date :	signed (Month,	Day, Year)
+ 3 <del>+</del> 1	1		· and	H				78	34	9	8%	186	
Inm	1		30. Name and address of person who	completed cause	e of death (Iter	m 23a) (Type,	Print)	- 1 - 1			1-1	- 7	
UII			WILLIAM ROBINS,				, SALIS	BURY, I	MD.	21804			
Po	Stat	-61	31. Date filed (Month, Day, Year)		egistrar's Signa	M. de	marke?						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 2006 11:55 AM Levin Robert Overton Jr. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GOOD SAMARITAN HOSPITAL BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**Д**М 2□ F Days 13,1928 Maryland Yrs. 218-24-5010 77 October Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Show ir than "natural", or itams 23a or 28a-f shov the Medical Examinar must be nutified at 1 X Yes 2 □ No Delaware Sussex Delmar Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 19940 1000 Fuller Place Apt. 2 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 No If Yes, Give Marine Year or Dates: Corns 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Midowed 4 Divorced White Corps Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Shore Distributors Salesman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other treumatic avant once. Eula Banks Levin Robert Overton Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Amy Grant/Daughter 4136 Nicholas Mews Salisbury, Maryland 21804 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 4 ☐ Donation 5 ☐ Other (Specify) 8/5/06 Salisbury, Maryland Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 DEUTOLI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVELE **Physician** /Medical Due to (or as a consequence of) **Examiner** ) [ NGTY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): neral Diractor: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Wunknown DIFFICILE COLITI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 🗌 Yes 2 12 No 1 Yes 25. Was case reterred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 PNatural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALIM BAGHLI - GOOD SAMARITAN HOSPITAL RALTIMORE -MD - 21239 31. Date filed (Month, Bay, Year) 2 2006 32. Registrar's Signature State Olakur Si ADDIE Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July 25, 2006 Year Elizabeth **Physician** Powell 0001 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince George's Prince George's Hospital Center 8. Date of Birth (Month, Day, Year) 2/19/15 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex / Funeral Months 1□M 2∰F Days Hours 91 Norfolk, Va. Director 579-58-2555 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Item 27 is marked other than "natural", or Items 23s or 28s-f show other treumatic event, the Modical Examinar must be notified at 1 □ Yes 2 No D.C. Washington Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2 should be filed within 72 hours after death with is and Mental Hygiene. Is marked other than "natural", or Itema 23a or 2 U.S.A. 20019 5000 Nannie H. Burroughs Ave., N.E. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 21 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White etc. African-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify American 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Domestic Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daniel McLean Melissa Royster Johnit. Pages 1 and 2 shr. Department of Health and N. Important: If Item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jacqueline Taylor/Niece # 42 Cobber Lane, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cem. 7/29/06 Washington, D.C. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility H.S.Washington & Sons Co., Inc. 21. Signature of Funeral Service Licensee anu 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Severe Peripheral Vascular Disease 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Bilateral Above the Knee Amputation certificate has Anemia Pernicious Dementia 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Dire 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. (Check only the 29b. Signatule and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D22435 July 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Acquanetta R. Frazier, M.D. 11120 New Hampshire Ave., Silver Spring, Md. . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 2006

			For State	State of Maryland	/ Department of H Certificate of	Health and Mental F Death	211116	25930
	201 80 T T	-	Registrar  1. Decedent's Name (First, Middle, Las	t)	- Cortinoato or	2. Date of		3. Time of Death
	Physici	- 10	Isiah	H. Pearson	7	Month	LY 23 3006	8:03 PM
4.3	/Medic Examin	47	4a. Facility Name (If not institution, give			or Location of Death	4c County of Dea	th
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	Funeral		5. Social Security Number 6. So	9X 7. Age (In yrs. las	st birthday) If Under 1 Year Months Days	Hours Min. 8. Date of Month,	Day, Year) _ Co	thplace (State or Foreign ountry)
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	yland		10a. State 10b. County		Town or Location			10d. Inside City Limits
	a-1 at	ctor	Md Prince 6	reorges C	apitul Hei	ights		1 Yes 2 No
	or 28	Funeral Director	10e. Street and Number	. 1	10f. Zip Code		10g. Citizen of What Co	ountry?
	ath w	rail	5906 Old Centr			0743	USA	
	ltem.	une	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	. 13. Was Decedent of I	Hispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.)	No- 14. Race - Ame Black, Whit	
336	urs af	To Be Completed by	3 Widowed 4 Divorced	If Yes, Give 8-24-/ Year or Dates 2-23-/	944 1 Yes 22 No	Specify:	Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ahow the Medical Examiner must be notified at		15. Decedent's Ed (Specify only highest gra	ucation	16a Decedent's Usual Occur	pation during most of working	16b. Kind of Business	/Industry
2	ithin 7		Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire		Percet	Industry
	filed w Hygier other th		17. Father's Name (First, Middle, Last)		Trucic	18. Mother's Name (First, Mid		Industry
anc	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Marolai Hygiens. Department of Health and Marolai Hygiens. Interportant if I fam 27 is marked other than "natural", or flems 23a or 28a-f show mopriant; if I fam 27 is marked other than "natural", or litems 23a or 28a-f show any Injury or other traumatic avant, the Madical Examiner must be notified at ance.		11:11.	ursan		Emma C		
Maryland	shouk hd Me mark imatk		19a. Informant's Name/Relationship (		19b. Mailing Address (Street	and Number or Rural Route Nu	mber. City or Town. State.	Zip Code)
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re,	of Heal		20a. Method of Disposition	20b. Pla	ice of Disposition (Name of metery, crematory or other pla	Date	20c. Location - City or	
E	Pages nent of ant; if it ury or o	1	1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	cala Hemor	7-29-200	b Suitland	d, Md.
Baltimore	permit. Pages Department of Important: If I any Injury or one		21. Signature of Funeral Service Licen	see	Name and Addre	ess of Facility Fune,	ral service	ie
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DHMH 17 Rev 1/2001

Registrar

			1 = For State Registrar	State of Ma	aryland /	-	artment rtificate			and M		giene Reg. No.2	006	25932	
			1. Decedent's Name (First, Middle, Last,								2. Date of Dea Month	ath Day	Year	3. Time of Death	
н	Physici /Medio		Joseph Leon	Pi1	kerton						August		06	3:25 p.m.	
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or	Location o	of Death			nty of Death		
			38506 Ted Drive				If Under 1		enue	24 Hrs	O. Data of Bird		St. Ma		
-	Funeral		5. Social Security Number 6. Security Number 12.	M 2□F	e (In yrs. last b 77	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da Feb. 2.	y, Year)	Cou	place (State or Foreign intry) yland	
	Director		220-26-6458 Usual Residence of Decedent		//						reb. Z.	J, 1929	Hall	y Land	
	yland		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits	
	a-fel	ctor	Maryland St. Ma	ry's				Ave	nue					1 ☐ Yes 2 💢 No	
	or 28	Oire	10e. Street and Number				10f. Zip C					10g. Citizen	of What Cou	intry?	
	ath w	rai	34300 11-11-11-11				206		: 0/0-			United States  14. Race - American Indian.			
	er de	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 Married 1 ∑ Yes 2 □ No 1951-			If Yes, specify Cuban, Mexican, Puerto Rican, e					Iслу Yes or No Rican, etc.)	) Black, White, etc.			
36	irs aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1956		1 □ Yes 2 <b>3</b>	No No	Specify:			Spe	city: Wi	nite	
21215-0036	d within 72 hours after death with the Maryland Jene. Ir than "naturel", or Itema 23a or 28a-1 ehow The Macical Exaciner rout the notified at		15. Decedent's Edu	cation		a. Dece	dent's Usual	Occupa	tion	t of works	na	16b. Kind o	f Business/li	ndustry	
215	within 7 ene. than "n	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)						OI WOIN	''y		ryland			
	illed wi Hygien other th	Con	12				Superi	inte			/Piers Adiedele			ministration	
pu	be filed tal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		пате)		
3	d Mer d Mer nark	2	George Arthur Pil  19a. Informant's Name/Relationship (7)		10	Dh Maili	na Address /	Street a			Istelle		wn State Z	in Code)	
Maryland	d 2 sl th an th an traur		Mary Agnes Pilker				,				, Mary			<i>p</i> 0000,	
ē,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Ie marked any injury or other traumatic e once.		20a. Method of Disposition				osition (Name matory or oth				ate		on - City or T	own, State	
JO	ages ent of nt: If i		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		1					8-12	2-2006	Leona	rdtown	MD.	
Baltimore,	mit. Postmoontar		21. Signature of Funeral Service Licens		Onarr									ne, P.A.	
ã	Dep Imp		Edward W. Brinsiie	ld, Jr.	M00052	100								20650-0279	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused	the death. D	o not en	ter the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition		Van	ci	nam	al	otes	10				Onset and Death	
1			resulting in death)  Due to (or as a consequence of):								307				
B		_	Sequentially list conditions, b. + Soulais Cancer 3,40								3,400				
	ed sit	nine	if any, leading to initilediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a cu sequeno	a utj.								U	
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	e of):				-					
120	ate be executed hysician and the burial-transit	caiE		d											
99	tificating phy as the	ed										4			
Вох	death certifica e ettending pt id for use as ti	2	1F FEMALE: 23b. Was decedent pregnant 1								23d.	23d. Date of delivery  Month Day Year			
		sicis	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at			Other (spe						MONTH	Day Year	
P.0	The law requires that the diste has been signed by the bage 2 should be detached	Physician/M	Part II. Other significant conditions contributing to death burnot resulting in the underlying cause given in Part I.							23e Did t	d tobacco use contribute to the cause of death?				
JS,	ires the signer of the d	by									Yes 2 ♥ No 3   Probably 4   Unknown				
Ö	w requir been s should	etec	0.	1-001	119	205	10	,			24a. Was	20 2	th Ware au	topsy findings available	
Record	The lav	ompieted		iona	1/1/20	5.XX					autor	psy prmed?	prior to c death?	ompletion of cause of	
		e Co	25. Was case referred to medical						26 Place	of Deat	1 Yes		1 🗆 Yes	2 No	
Vital	Phyaician: rthis certific ral director,	0 8	avaminar?	Hospital: 1 ☐ Inpatie	26. Place of Death (Check only one)  Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)										
10	ding Ph h. After thi funeral	i.T	27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?								28d. Describe how injury occurred				
Š	Attending or death.	atlo	2 Accident investigation M 1 Yes 2 No						No						
Division	7 = F	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At home, c. <i>(Specify)</i>	farm, st	reet, factory,	office			28f. Location ( City or To		umber or Ru	ral Route Number,	
Ω	urs af		Constitute Physical P	rainiam. To the book	of my knowled				data as	d place	and due to the	(-)		stated	
	Hospital of 24 hours at 0 Funeral D letely filled i	edicai		sician: To the best iner: On the basis o and manger st	f examination										
	To the Hos within 24 h To the Fun completely	₹ Z	29b. Signature and title of certifier	01	1	, ,	29c.	License	number			29d. Date si	gned (Month	n, Day, Year)	
	->-0		b hma	St. hon	MEA	11	( )	D	06	41	9	8-	11-0	26	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
				м. п., 240	35 Thr	ee N	otch F	Road	, Hol	L1ywc	od, Man	ryland	20636	5	
	St Regist	ate	31. Date filed (Month, Day, Year)	2006 32. Resistr	ar's Signature	K	god.	9							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 0855 M MER NUIC 2006 DYC 31 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. Kegional medical Center reninsula NICONICO Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 216-70-7493 Usual Residence of Decedent Director the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County nen zz is marked other than "natural", or items 23s or 28s-f eho: other traumatic event, the Medical Exemplat must be notified at 1 Yes 2 No Director WD CDMICO ISBURG 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number JA 20 Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: RUX Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) EPRESENTATIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fand Mental 8 HARMON ည ORIS VA LDNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelith and Important: If Item 27 is m any injury or other traum once. 611- DENNIS SAUSBURY KENNETH L. PALMER - HUSBAND MD-21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 7/06 4 ☐ Donation 5 ☐ Other (Specify) 8 EMETERY Funeral Service Licenses BENNIE 22. Name and Address of Facility SMITH 15ABELLA MA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. metastri Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Deen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificete hes autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 Yes After this certification, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 300 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending М 1 Yes 2 No investigation To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2050) 30. Name and a dr ss of person who completed cause of death (Item 23a) (Type, Print) 6RASSO 100 E. CAMPOLL ST. SALISBURY Md 21801 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Trivisiah Rodriquez 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 31, 2006 0100 hrs Trivisiah Niree Rodriguez Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Locust and Franklin Street Hagerstown If Under 1 Year Uf Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9 Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 111-70-3594 Country) New York Director April 9 1986 2 X F 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ž 1 X Yes 2 No Washington Hagerstown 28a-f shov Maryland death with the Maryland rector 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 23a or 28a-notified at 21740 U.S.A. ö 56 E. Antietam St. Apt. R2 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian Black 12. Was Decedent Ever in U.S. Funeral must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Black Specify: Widowed Divorced If Yes, Give Year Yes 2 No specify. \$ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) ages 1 and 2 should be filed within 72 1 ant of Health and Mental Hygene it: If item 27 is marked other than " other traumatic event, the Medical E Personal Residence Homemaker Baltimore, MD 21215-0036 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara G. Broadus Emilio G. Rodriguez Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဂ္ 21740 53 E. Talita L. Rodriquez (step-mother) Franklin St Apt Hagerstown Maryland 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State crematory or other place) Smithsburg Crematory Aug 5 06 Smithsburg Maryland Important: injury or of Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of F neral Service Licens Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and 23a Part I. Enter the disease, or complications Physician failure. List only one cause on each line /Medical Death a. Gunshot Wound to Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): - tran Physician/Medical **AMENDED** UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? certificate has ✓ Yes 2 No 2 No 1 🗸 Yes 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 ✓ Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Jul 31, 2006 28b. Time of Injury 27. Manner of Death Subject was shot 0100 hrs 1 Yes 2 ✓ No Pending the Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Locust and Franklin Street, Hagerstown, MD (Specify) Sidewalk 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie O.C.M.E July 31, 2006

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State

**ORIGINAL** 

111 Penn Street, Baltimore, MD 21201

ne and address of person who completed cause of death (Item 23a)

2006

Assistant Medical Examiner

Melissa Brassell, MD

31. Date filed (Month Day)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DOZZ AM Marvin Greenwood RODGERS 2006 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1⊠M 2□F Yrs. 73 214-30-2016 Director 13, 1932 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16812 Longfellow Court 21740 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed v
Department of Health and Mental Hygas
Important: If item 27 is marked other it
any nijury or other traumatic event, tha custodial school board 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edgar Casper Rodgers Ida Belle Rankin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Rodgers - wife 16812 Longfellow Court, Hagerstown, Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 8/9/06 Hagerstown, Maryland 21. Signature of Funeral Service Licensee -22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or comblications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Completed by Physician/Medical Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ò Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Chipity ( but) 1 Yes 2 🗌 No 3 Probably 4 Unknown paga 2 should 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 FR/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending within 24 hours after death. To the Funeral Diractor: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled Hospital 10. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place; and due to the cause(s) and manner at stated:
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29c. Liçense number 29d. Date signed (Month, Day, Year) 29b. Signat n who completed cause of death (Item 23a) (Type, Pring) STETHEN E. METEREN MA 124 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 Pear **Physician** July 29<sup>ay</sup> Fellia J. Savage 6:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Riderwood Nursing Home Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. Director 177-05-4330 90 April 6, 1916 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Itams 23a 2212 Solmar Drive 20904 USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. s 1 and 2 should be filad within 72 hours aftar in thealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White δ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Michael Polakoski <u>Antonia Bogdanski</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Solmar Drive, Silver Spring, MD Richard Savage/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Fort Lincoln Cemetery 8/1/06 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fort Lincoln Funeral Home
3401 Bladensburg Rd., Brentwood, Maryland
Approxim 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of rying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Opath Immediate Cause (Final disease or condition resulting in death) crof 80 Physician win /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 10 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 06 31 DO04337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rd. Silver Spring, MD 20904 Karen Merritt, 31. Date filed (Month, Day, Year) State AUG 0 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** July Robert Frank Seagears 19. 2006 3:15 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2217 Richland Street Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F 73 Yrs. 579-40-6785 1933 South Carolina Director May 23, Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State in then "neturel", or Items 23e or 28e-f show the Medical Examinar must be notified at 1 ¥ Yes 2 □ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 United States 2217 Richland Street Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Oct.1950

1 X Yes 2 No Oct.1950

II Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or DatesOct. 1970 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1 year Military Enlisted United States Army other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be find Mental I Sarah Murphy Dove Seagears ဥ 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Jean Deloris Smith Seagears 2217 Richland Street; Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ott July 25,2006 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature o Funeral Sento Consee 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Rectal Carcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner death certificate be executed Causa (Clacase or Figure that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE 981 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death Ö detached à ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has perfor 2**X** No 1 🗌 Yes 2 No 1 ☐ Yes Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 🗌 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide 24 hours a Funerel I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cai and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 28, 2006 01012365 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) Walter Reed Army Medical Center Joshua D. Hartzell, 6900 Georgia Avenue, N.W.; Washington, D. C. M.D. 31. Date liled (Month, Day, Year) 2. Registrar's Signature State JUL 3 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Manote Sounrut 8:05 PM 07/25/2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facifity Name (If not institution, give street and number) Examiner Montgomery Rockville Casey House / Montgomery Hospice If Under 1 Year | ff Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpface (State or Foreign Country) **Funeral 1**X M 2 □ F 577-86-2492 Thailand 04/25/1933 Director 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23s or 28s-f show the jujury or other treumatic avant, the Medical Exact Lear must be restitled an once. 1 ☐ Yes 2 No Bethesda Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Thailand 20817 7517 Spring Lake Dr. Apt. B2 by Funeral 12. Was Oecedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Thailand Army Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Suwansupa Rabiab ဥ Sounrut Nark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7517 Spring Lake Dr. Apt. B2
Bethesda, Maryland 20817

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charintorn Sounrut / Wife 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Busia 2X Cremation 3 □Removal from State 07/30/2006 Alexandria, Virginia 6 ☐ Ofher (Specify) Everly Crematory 22. Name and Address of Facility Everly-Wheatley Funeral Home 1500 W. Braddock Rd. 21. Signatus Alexandria, Virginia Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication, that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each fine. fmmediate Cause (Final **Physician** Lung Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and burial-transit Due to (or as a consequence of): ed by the attending physicien detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? δ page 2 should be 3℃Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performed? 1 ☐ Yes 2 🖾 No t ☐ Yes 2 ☐ No or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice IRU ဥ 1 ☐ Yes 2 No 2 ER/Outpatienf 3 DDA this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending investigation М 1 Tes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the V within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Ognitis m Billiams, D.O. H0058032 July 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montgomery Hospice Good Muncaster Mill Rd Rockville, MD 20852 CYNTHIAM. WILLIAMS, DO 31. Date fifed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

JUL 3 1 2006

			1 - For State Registrar	State of Marylar			nt of Health te of Dea		_	giene Rag. No.	200	5 259	39
	Physici	an	Decedent's Name (First, Middle, Last)     KUM OK S	OHN					2. Date of De Month JULY	ath 26 <sup>Day</sup>	200 <sup>Yaa</sup>	3. Time of D	eath A M
£.	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City	Town, or Location	on of Death	0021	4c.	County of De		
				HOSPITAL	last histhday)		SILVER	SPR.	ING 8. Date of Bir		ONTGO	MERY iirthplace (State or F	Foreign
В	Funeral Director			7. Age (In yrs.	Yrs.	Months			(Month, Da	y, Year)	S	KOREA	Or engri
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation			001 2			10d. Inside City	Limits
	Maryl a-f eho	iot	MD MONTGO	MERY WH	EATON							1 <b>∑</b> Yes 2	No
	vith the	Director	10e. Street and Number	DII DD		10f. Zi	Code 20902			_	zen of What ( JSA	Country?	
	ne 23	Funeral	4011 RANDOL	12. Was Decedent Ever in U	.S. 13.	Was Dece	dent of Hispanic	Origin? (Sp	ecify Yes or No		14. Race - Ar	nerican Indian,	
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "naturel", or iteme 23a or 28a-f ehow marked other then "naturel", or iteme 25a or 28a-f ehow marked other than Medical Examinar mark ha notified at	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		lf Yes, spe 1 □ Yes	cify Cuban, Mexi		Hican, etc.)		Black, Wi Specify:	ASIAN	
Maryland 21215-0036	2 hour	ted b	3 X Widowed 4 ☐ Divorced  15. Decedent's Edu		16a. Dece	dent's Usu	al Occupation			16b. Kir	nd of Busines		
1215	vithin 7 ne. hen "n	Completed	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT	ork done during n ise retired)	tost of work	ing	ומת	CVATE		
d 2	Hygie Other t	Be Co	17. Father's Name (First, Middle, Last)		ноо	SEW]		other's Name	e (First, Middle				-
ylan	should be ind Mental marked o	To B	BYUNG HA P.	ARK			S		YOO		1		
Mar	d 2 a d 2 a		19a. Informant's Name/Relationship (Ty) DAVID SOHN	pe, Print) / SON			s (Street and Nu AN WOOD					, Zip Code) 20854	
Baltimore,			20a. Method of Disposition  1 N Burial 2 Cramation 3   R		Place of Dispo cemetery, crei	osition (Na matory or	me of other place)	1	Date	20c. Lo	cation - City	or Town, State	-
Œ.	t. Pa rtmen rtant:		4 □ Donation 5 □ Other (Specify)  21. Signature of Fundal Articles	NC			IORIAL nd Address of Fa	100	29/06	OLI		MD	
Ba	Department of the partment of		· Will	2			KAYAK	CHA				NERAL SE MD 2077	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dealer cause on each line.	th. Do not en	ter the mo	de of dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Betwee Onset and De	
	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	CEREBROVAS  Due to (or as a consec			ACCI	DENT				2 DAYS	S
	Examiner	L	Sequentially list conditions,	HYPOTENSIC								1 WEEK	ζ
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	(uence of):								
, 0,	death certificate be executed the attending physician and of for use as the burial-transit	I Exa	resulting in death) Last	Due to (or as a consec	quence of):								
68760,	ficate by physical for the b	edical											
XO	eath certific attending p	Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1□Live birth 2□Feta		∃Ectopic p	regnancy			2	23d. Date of o	delivery Day Ye	21
O. B	that the dea ed by the at detached fo	yslci	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of of 9 Unknown	death 5	Other (s	pecify)				worth	Day	Q1
<b>a</b>	8 5 9	by Pł	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying	cause given in Pa	art I.				to the cause of dea	
ord	w requir been si should I	eted					-		10		7	Probably 4 Un	
Rec	The law ate has page 2	Completed							24a. Was autoj perfo		prior t death	autopsy findings av o completion of cau ? es 2 X No	se of
/ital		BeC	25. Was case referred to medical examiner?					ace of Deat	h (Check only o				
<del>6</del>	Physician: r this certific ral director.	. T	1 ☐ Yes 2X No  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		28c. Injury at		me 5 Resi			pecify)	
ion	Attending r death. ector: After by the fune	atlor	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2	□No					
Division of Vital Records,	or Attending Physician: efter death. Director: Atter this certific I in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	reet, factor	y, office		28f. Location ( City or To			Rural Route Numbe	er,
_	To the Hospital or At within 24 hours efter d To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examina	owledge, deat	h occurred	at the time, date	and place,	and due to the	cause(s)	and manner	as stated,	
	To the h within 24 To the F complete	Med	one)  29b. Signature and tytle of certifier	and manner stated.			c. License numb					inth, Day, Year)	
)	F 3 F 8		· Mwx	~ ~ ~			D 3281	.7			26/06		
2	(3)		30. Name and address of person who come M WAJEED KHAN				TTE WILL	ΔηιΩNī	MD 2	0902	)	-	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature _		ZAE MUE	MION	עום ב	0 9 0 2			
4.5	Regist	ar	1111 2 8 2006	Here K	25204								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? Decedent's Name (First, Middle, Last) 2. Date of Death JULY Physician  $2^{\text{Day}}$ , CHRISTINE SHERROD 2006 8:57 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGE'S LAUREL 7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
Months Days Hours Min.
10-07-1927 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 21X F 225-34-7582 N. CAROLINA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 'natural', or Itema 23a or 28a-f show oldal Experient formal by netiting at 1 Yes 2 No Directo PRINCE GEORGE'S BELTSVILLE M.D. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 4808 BRIGGS CHANEY RD. 20705 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. filed within 72 hours after Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: BLACK Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. the Ma Elementary/Secondary (0-12) 10th College (1-4or 5+) FOSTER CARE PROVIDER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic eventance. Be HARRY SHERROD ELIZABETH STATON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4808\ BRIGGS\ CHANEY\ RD$  . 19a. Informant's Name/Relationship (Type, Print) 4808 BRIGGS CHANEY RD.
BELTSVILLE, M.D. 20705
te of Disposition (Name of MILDRED SHERROD/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State NORBEC MEMORIAL 08-01-06 OLNEY, M.D. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility TAYLOR 'S FUNERAL HOME 21. Signatuje of Funeral Service License 1722 N. CAPITOL STREET, NW WASHINGTON, D.C. 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed CORONARY ARTERY DISEASE that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) bed 1 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à DIABETES MELLITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2⊠No certificate 1 ☐ Yes 2X No 1 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident completely filled in by the Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053337 07-25-2006 impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 10801 LOCKWOOD DRIVE, SUITE#205 SILVERSPRING, MD 20901 DOROTHY SEAY, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

2 8 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

#### 06-05618

Thomas Samual Sherwood, Jr.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		Registrar	Certificate of	Death		Reg	j. No () () ()	7701
Physic	ian/	Decedent's Name (First, Middle, Last)		_		Date of Death     Month	Day Year	3. Time of Death 1219 hrs
Medical Exan	iner	THOMAS SAMUEL SHERWOOD, J		In City Town o	Location of Death	July 31, 20	4c. County of Death	12191118
		4a. Facility Name (if not institution, give street and number) 5696 Gates Road	4	Bellrue	Bejlevue		Talbot	
Funera			yrs. last birthday)	If Under 1 Yea			(MM/DD/YYYY) 9. Birt	hplace (State or
Directo			49 Yrs.	Months Day	/s Hours Min		Foreig 16, 1956 Co.	nuntry MARYLAND
any			. City, Town or Location	on				10d. Inside City Limits
nd show	اۃ	MD TALBOT	EASTON					1 Yes 2 X No
ic Maryland or 28a-f show any fied at once.	Director	10e. Street and Number		10f. Zip Code		10	g Citizen of What Cour	itry?
ith the Maryland 23a or 28a-f sho	盲	29144 HOLLY ROAD		216			USA	
) 72 hours after death with the Maryland n "matural", or items 23a or 28a-f she a Fevaniner must he notified at one	1 61	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X	No If Ye	es, specify Cuba	spanic Origin? ( S n, Mexican, Puerto		14. Race - Americ White, etc.	
s after ral",	b	3 Widowed 4 Divorced of Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete		44	specify: ation (Give kind of	work done	Specify: WH 16b. Kind of Business/li	ITE
hours after "natural",	ted	15. Decedent's Education (Specify only nignest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)			e. DO NOT use ret		TOD. KING OF BUSINESSA	ndustry
36 hin 72 than '	Completed	12	WAT	ERMAN			SEAFOOD	
21215-0036 old be filed within 72 Mental Hygiene marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than marked other than the same than the	Son	17. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, M		-
215 be file meal H	B B	THOMAS S. SHERWOOD, SR.				LY BRANSI		
D 2121 should be f and Mental 7 is marked	2	19a. Informant's Name/Relationship (Type, Print )	.94	,			per, City or Town, State	, Zip Code)
ore, MD s I and 2 shu of Health and If item 27 is		THOMAS S. SHERWOOD, SR./FATH  20a. Method of Disposition	20b. Place of Disposi			ASTON, MI	21601 20c. Location - City or	Town State
Baltimore, MD 21215-0036 powii Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Integrating Them 27 is marked other than "natural", integration of health and property than "natural",		1 Burial 2 X Cremation 3 Removal from State	crematory or oth		Silicitory,	53.0	200. 200d.John Gity of	70mij otato
Baltimore				E CREMAT		8/2/200	5 STEVENSV	ILLE, MD
Balt pomit Depart	<	21 Sizelle e of Funeral Service Licensee Joseph M. Ostzoush C. F				IN_&_NEWN	NAM FUNERAL MD 21601	HOME PA
Physicia		23a. Part I. Enter the disease, or complications that caused the	death. Do not enter the	O S HAI ne mode of dying	RISON S' , such as cardiac	or respiratory arre	MD 21601 st, shock, or heart	Approximate Interval
Medica	8 1	failure. List only one cause on each line.  Immediate Cause (Final disease a, Multiple Gunshot W	Vounds					Between Onset and Death
Examine		or condition resulting in death)  Due to (or as a conseque						
795		Sequentially list conditions, b						
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O, e be executed ysician and	al E	d.						
760, Trate be execute physician and	Medical	UNPENDED AMENDED						
76 Cai	1 2	IF FEMALE: 23c. If yes, outcome of 23c. Was decedent pregnant in the	constant of the same of the sa	tal death 3	Ectopic pregn	nancy	23d. Date of delivery  Month	/ Day Year
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, P.O. B.	by P	Part II. Other significant conditions contributing to death but	t not resulting in the u	inderlying cause	given in Part I.		2 No 3 Prob	
S .50		·				24a. Was a		topsy findings available
Cords, law requir	ple					autops	sy prior to o	completion of cause of
	٦					1 Yes 2		es 2 No
Vital Reorganicanicate	Be	25 Was case referred to medical examiner? Hospital: 1 Inpatient	2 ER/Outpatient		Other Nursi		Residence 6 🗸 Other	r. Pagna
of Vir of Vir ig Physic ig Physic	3   <b>-</b>	1 Ves 2 No Inospital 1 Inpatient 27. Manner of Death 28a. Date of Injury	28b. Time of I		ury at Work?	<u> </u>	ow injury occurred	Scerie
A 6 on of N iding Phy th.	ioi	1 Natural 5 Pending Jul 31, 2006	1120 hrs		Yes 2 ✔ No		shot by police	
Division  Train or Attendin  Train or Attendin  Train or Attendin  Train or Attendin  Train or Attendin  Train or Attendin	Certification:	2 Accident Investigation 28e. Place of Injury	- At home, farm, stree	et, factory, office	building, etc.	28f. Location (S	treet and Number or Ru ate) Bellevue	ral Route Number, City
Division of contract of the co	ertif	Suicide 6 Could not be determined (Specify) Dock				or Town, St 5696 Gates	Road, <del>Bellrue</del> , Mo	l.
the Box	Medical C	29a. Certifier 1 Certifying Physician: To the best of my kn one) 2 Medical Examiner: On the basis of examinar						
To witi To	Mec	29b Signature and title of certifier		29c. Licer	nse number		29d. Date signed (Mo	nth, Day, Year)
		his his mos		0.0	.M.E.		August 1, 2006	
3		30. Name and address of person, who completed cause of death	h (Hem 23a)	-				
		Ling Li, MD Assistant Medical Examiner	111 Penn Stree	et, Baltimore	, MD 21201			
	State istrar	31. Date filed (Month, Day, Year)  Registrar's S	Signature			42.00		

				State of						l Copies A lental Hygi	•	ne.	50010
			1 = For State Registrar		, , , , , , , , , , , , , , , , , , , ,	•	rtificate				g. No.	6	25942
	Na		1. Decedent's Name (First, Middle	, Last)						2. Date of Death Month		Year	3. Time of Death
, 1	hysici: Medic/		BERTHA SOHN							JULY 31,			5:20 P M
	Examin	er	4a. Facility Name (If not institution	•					ation of Death		4c. County o		
			HEBREW HOME OF G			last birthday)	RUC If Under 1	CKVILLE Year   If U	Inder 24 Hrs.	8. Date of Birth	MONTGO		place (State or Foreign
	uneral rector		116-03-5482	1□M 2√2F	90	Yrs.	Months D	Days Ho	ours Min.	(Month, Day, AUGUST 7,		NEW Y	place (State or Foreign htry) YORK
land	M II		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	Od. Inside City Limits
Магу	Hed a	to	MARYLAND MONTGO	MERY	RO	CKVILLE							1 ☐ Yes 2 🖺 No
th the	or 286	Director	10e. Street and Number				10f. Zip Co	ode		10	g. Citizen of W	hat Cour	itry?
ath wi	23a unst b	ral	6121 MONTROSE ROAD					20852			USA		
er de	Items Inc.	Funeral	11. Marital Status	12. Was Decede	es?	.S. 13.	Was Deceden If Yes, specify	nt of Hispan Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)		- Americ , White,	can Indian, etc.
III C F F 15-0000  be filed within 72 hours after death with the Maryland ital Hygiene.	Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show eny injury or other treumatic event, the Medical Examinar must be rediffied at once.	by F	1 ☐ Never Married 2 ☐ Marr 3 🖫 Widowed 4 ☐ Divorced	ed 1 Tes 2 If Yes, Give Year or Date			1□Yes 2≹	No Sp	ecify:		Specify:	CAT	JCASIAN
5 PG 75	leal E		15. Decedent	's Education		16a. Dece	dent's Usual C	Occupation	most of worki	1	6b. Kind of Bus	iness/Inc	dustry
ithin 7	Med T	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use i	retired)	THOSE OF WORK	ng			
led w lygier	it.		47 Fathada Nama (First Middle)	5+		LIBRAI	RIAN	10.1	Mashada Nama		FEDERAL C		IMENT
d be fi	ed of	Be	17. Father's Name (First, Middle, JACOB SCOOLER	.ast/					Mothers Name IDA GOTM	e (First, Middle, M AN	alden Sumame	,	
should Ind Men	mark	2	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address (S			al Route Number,	City or Town, S	State, Zip	Code)
and 2:	27 ls or treu		DANIEL SOHN - SON			4160	VISTA G	RANDE:	MARIPOSA	A CA 95338			
es 1 g	r othe	3	20a. Method of Disposition  Y□ Burial 2 □ Cremation	3 <b>V</b> Domoval from St		lace of Dispo	sition (Name matory or othe	of			Oc. Location - C	City or To	wn, State
Pages ment of 1	<b>P</b>		`4 □ Donation 5 □ Other (S						CEM. 8/4	/2006 W	ASHINGTON	, DC	
permit. Pages Department of	mpor in in		21. Signature of Funeral Service	icensee	- P		2. Name and A			NES-RINALD			
	_		23a, Part1, Enter the disease, or	complications that cau	sed the deat							20904	Approximate
Phys	sician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.				DISI		51,		Interval Between Onset and Death
/M	edical		disease or condition resulting in death)	a Due to (or	as a conseq		11116	12	1/130	1136			***
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рө	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or	as a conseq	uence of):							
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te be executed	nysician and he burial-transit	caiE		d									
rifficat	been signed by the attending phys should be detached for use as the	1000	IF FEMALE:										
S up	ttendi	an/I	23b. Was decedent pregnant in the past 12 months?		h 2 🗌 Feta	Ideath 3	Ectopic pregi	nancy			23d. Date Mon		ery Day Year
he de	the a	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnar 9□ Unknow	it at time of d	eath 5□	Other (speci	ify)			Wien		Day
that	ed by detac	y Ph	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	nderlying caus	se given in	Part I.	23e. Did tob	acco use contril	oute to th	ne cause of death?
quires	n sigr uld be	ed by	DIABE:	IES M	ELLI	1745	5-141	PE 2		1 🗆 Ye	3 3 No 3	3 🗌 Prob	ably 4 Unknown
a v	s bee 2 sho	Completed								24a. Was an			psy findings available
The	is certificate has director, page 2 a	Com								autopsy perform	eat? de	eath?	mpletion of cause of 2□ No
cien:	ertific octor,	Be (	25. Was case referred to medical examiner?						Place of Death	(Check only one			
hysi	this c al dire	2	1 ☐ Yes X No	Hospital: 1  Inp		ER/Outpatier		-		me 5 Resider			1)
ding i	After	tion	27. Manner of Death  1 Natural 5 Pendin  2 Accident investig	9	Day Year)	28b. Time of Injury	28c.	injury at Work? 1 ☐ Yes		28d. Describe hov	v injury occurre	0	
Atten	ector: by the	ifica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place of	Injury - At ho	ome, farm, str	eet, factory, o		-	28f. Location (Str		r or Rura	I Route Number,
s afte	od in t	Certification:	4 Homicide	building	, etc. (Specif	γ)				City or Town,	State)		
To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death.	To the Funerel Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the b Examiner: On the bas and manne	is of examina	wledge, death tion and/or in	n occurred at t vestigation, in	the time, da my opinior	ate and place, n, death occurr	and due to the cared at the time, da	use(s) and man te and place, ar	ner as st nd due to	ated. the cause(s)
To the	To the	Me	29b. Signature and title of certified				29c. L	icense num	nber	29	d. Date signed	(Month,	Day, Year)
- >			> Due	15 au	wi	w	7)	00	180	84 1	14049	16	1 2006
1			30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	1001	Thee	00/	)	(11	1/Mn -
			31. Date filed (Month, Day, Year)	FHTEL	istrar's Signa	). ()(	2/14	UNI	ROSE	Ky o	WU/C	VIU	5 2000
	Sta Registr			2 2006	gers signa	B. A	DBALL!						

Physicia /Medic		1. Decedent's Name (i	First, Middle, DARRE		OUR					2. Date of Do Month 3 JULY	Day	2006 <sup>Year</sup>	3. Time of Death 12:16P N
Examin		4a. Facility Name (If no		-			4b. City		r Location of Dea	ith		County of Deat	
\$ ×	SAR	Laurel  5. Social Security Num		onal Ho		s. last birthday	if Unde	Lau		S. 8 Date of Bi			GEORGES
Funeral Director		047-48-44	178	<b>1</b>	5(		Months		Hours Mir		20 ,	1956 °	hplace (State or Foreig untry) Conn .
filed within 72 hours after death with the Maryland Hygiene. ther then "natural, or iteme 23e or 28e-f ehow ent. I've Medical Examiral must be notified at		Usual Residence of De 10a. State 1	ob. County		10c. 0	City, Town or L	ocation						10d. Inside City Limits
r 28a-f ehow	tor	MD I	rinc	e Georg	es	Ве	ltsv	ill	е				1 <b>y</b> Yes 2 □ No
or 28 De not	Funeral Director	10e. Street and Number		3 0	1 -		10f. Zi	p Code	0505		-	izen of What Co	untry?
must.	erai	11. Marital Status	2 Sno	al Cree	edent Ever in		Was Dece		0705	Specify Yes or No		J.S.A.	rican Indian
if, or iten	by Fun	1 Never Married 3 Widowed 4		Armed F	orces?		If Yes, spe			Specify Yes or Norto Rican, etc.)		Black, White	e, etc.
nature lical E	eted		5. Decedent's			16a. Dece	edent's Usu	al Occup	ation	orkina	16b. Ki	ind of Business/	Industry
rthen '	Completed	Elementary/Second		College (	1-4or 5+)				during most of wo				Reed Army
ent. II	0	17. Father's Name (Fin	rst, Middle, L		yrs	17.	<u>lealc</u>	aı	Techno]	LOGIST ame (First, Middle			Center
rked tic ev	To B	Willia	am Se	ymour					Autı	y Hend	erso	on	
7 is marked other then traumatic event. It e M		19a. Informant's Name Haley Se			\	1	_			Rural Route Numb			(ip Code) ,MD 20705
		20a. Method of Dispos		r (MTIG		Place of Disp	osition /Na	me of		Date		ocation - City or	
# 5 b		t Burial C □ 0		3 □Removal from ecify)	Say Ga	cemetery, cre	Hea	ven.	Cem 8/	7/06	Silv	er Spi	cing, MD
important: if item 2 eny injury or other once.		21. Signature of Fune	ral Service L	icem	rous								HOME, P.A. e,MD 2085
nysicia he bui	edicai Examiner	23a. Part1. Enter the shock, or heart in shock, or heart in the shock or condition resulting in death)  Sequentially list conding any, leading to immediate. Enter Underly Cause (Disease or injuthat initiated events resulting in death) Las	tions, equate ing ury	a. Se Due to b. Me Due to	psis (or as a conse	equence of):  tic Li equence of).						11	Interval Between Onset and Death 6 hours 5 month
	Physician/Med	IF FEMALE:  23b. Was decedent pr in the past 12 mc 1 ☐ Yes 2 ☑ N 9 ☐ Unknown	onths?		birth 2 ☐ Fe nant at time of	tal death 3	□Ectopic p □ Other (s		'			23d. Date of deli Month	very Day Year
eugi p eq	þ	Part II. Other significa	nt condition	ns contributing to c	leath but not re	esulting in the i	underlying (	cause giv	en in Part I.			_	the cause of death?
cate has been signer, page 2 should be	Completed									24a. Was auto perfo 1 ☐ Yes	psy ormed?	prior to death?	topsy findings available completion of cause of 2 ☐ No
s certificat lirector, pe	o Be	25. Was case referred examiner?  1 Tes 22 No		Hospital:	Inpatient 21	ER/Outpatie	ent 2 D	OA Oth		eath <i>Ch</i> eck only Home 5 ☐ Resi		C (10)	.4.1
r death. ector: After this certific. by the funeral director.	tion: To	27. Manner of Death	5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		28c. Injur Wor	4   Italiang	28d. Describe			iny)
s after death. il Director: Af id in by the fur	Certification:	3 Suicide 4 Homicide	6 Could no determin	288. Place	e of Injury - At ing, etc. (Spec	home, farm, st	treet, factor	y, office		28f. Location ( City or To	Street an wn, State	d Number or Ru )	ral Route Number,
	edical (	29a. Certifier 15 (Check only 20 one)	Certifying Medical E	Physician: To the xaminer: On the b and man	e best of my kr basis of examination stated.	nowledge, dear	th occurred ovestigation	at the tire n, in my o	ne, date and plac pinion, death occ	e, and due to the surred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
를 를 를	Me	29b. Signature and titl	of certifier	-0 11	(	1)	29	c. Licens	e number		29d. Dat	e signed (Month	, Day, Year)
6 4			/ 1/										

			1 - For State Registrar	State of I	Marylar				ealth a Death		F	Reg. No.	006	25944
i	Physic /Medi		1. Decedent's Name (First, Middle, La.  Elissa Scheinbe	rg							2. Date of Dea Month August	1,	2006	3. Time of Death 8:36A M
	Examir Funeral	ner	4a. Facility Name (If not institution, given 2015 Dundee Rd 5. Social Security Number 6. S			last birthday)	if Unde	Rock	Location of ville  If Under 2	24 Hrs.	8. Date of Birti	Me	ontgome  9. Bin	
	Director		Usual Residence of Decedent	□M 2 <b>∑</b> F		SO Yrs.	Months	Days	Hours	Min.	(Month, Day Aug 18		945 Ne	w York
	the Marylan r 28e-f show notified at	rector	10a. State 10b. County  Maryland Montg  10e. Street and Number	omery		ity, Town or Lo	1e	p Code				10g. Citi	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No
036	172 hours after death with the Maryland "natural", or iteme 23a or 28e-f show idical Examiner must be notified at	by Funeral Director	2015 Dundee Rd  11. Marital Status  1 □ Never Married ※☐ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1  Yes 27 If Yes, Give Year or Date	s? No		Was Dece	20850 Ident of Hi Incity Cuba		in? (Spec Puerto R	ifv Yes or No-	U	SA 14. Race - Ame Black, Whit Specify:	erican Indian,
0-61212	y within jiene. r then "	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-40	or 5+)	life.	kind of w	al Occupa ork done d ise retired,	uring most	of working	g		of Business	/Industry
Maryland 21215-0036	should be filed nd Mental Hygi marked other imatic event,	To Be C	17. Father's Name (First, Middle, Last)  Herbert Frankel  19a. Informant's Name/Relationship (			19b. Mailir	ng Addres	s (Street a	Mal	vina	(First, Middle,  Grossn Route Numbe	Maiden nan		
สรั	and 2 leelth a m 27 is her trau		Harold Scheinbe  20a. Method of Disposition  1	rg/Husbar	20b. I	201 Place of Dispo cemetery, crei	5 Dun	ndee me of other place	Rd R	ockv:	ille, M	ID 20 20c. Lo	0850 cation - City or	Town, State
Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot once.		21. Signature of Funeral Service Licer		200		2. Name a	nd Addres	s of Facility	Hine		.di 1	lney, M Funeral er Spri	D Home ng, MD 2090
	Physician and // Physic	Examiner	23a. Part1. Enter the disease or commondate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	Iyocar	cdial I quence of): cension	nfar			eardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
5	that the death certif ed by the attending detached for use a	by Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  Part II. Other significant conditions of	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta at time of o	al death 3 death 5 death	]Ectopic p ] Other (s	pecify)	n in Part I.		23e. Did to		3d. Date of del Month se contribute to	ivery Day Year the cause of death?
	The law requires ate has been signipage 2 should be	Completed b									1 Yes	med?	24b. Were au prior to death?	obably 4 Unknown utopsy findings available completion of cause of
o uc	Attending Physician: The death. r death. sctor: After this certificate by the funeral director, pages	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpa  28a. Date of ir (Month, I		ER/Outpatier 28b. Time of Injury		28c. Injury Work	r: 4 🗆 Nurs	sing Hom	Check only or 5 Resident	ence 6	Other (Spec	cify)
DIVISION	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At h etc. (Speci	ome, farm, str	eet, factor				If. Location (Si City or Town			ıral Route Number,
	the Hospi in 24 hour the Funer pletely fill	Medicai	29a. Certifier  (Check only one)  2 Medical Exam	ysician: To the be niner: On the basis and manner	of examina	owledge, death ation and/or in	occurred vestigation	at the tim	e, date and inion, death	place, an	d due to the c d at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
	Z with com	2	29b. Signature and title of certifier  Mauria	Role	dm	ouh,	MD 29	c. License	25348				signed (Mont) $1$ st $1$ ,	
3	Sta Registr		Marcia Goldmark 31. Date filed (Month, Day, Year)	MD 119	06-G strar's Signa	Darnes	town	Rd,	N. Po	tomac	e, MD 2	0878	3	

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Beleva

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H rtificate of L	ealth and M Death		jiene (	36	25946
	1. F		1. Decedent's Name (First, Middle, Las	")				2. Date of Dea Month	th Day	Voar	3. Time of Death
	Physici /Medi		Betty Jean	Snyde	r			August		Year 006	2:20 a.m.
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Hermitage at St.		ek		omons.			alver	t
	Funeral		5. Social Security Number 6. Se	x 7. Age ⊒M 2.XIF	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign ntry)
	Director		210-12-1387 Usual Residence of Decedent		82 Yrs.			Nov.28,	1923	Penn	sylvania
	land		10a. State 10b. County		10c. City, Town or L	ocation				1	IOd. Inside City Limits
	Mary Heh	ō	Maryland St. Man	1.0		Louineten	D - 101				1 ☐ Yes 2 📉 No
	28a	Director	Maryland St. Man  10e. Street and Number	уѕ		Lexington 10f. Zip Code	rark	1	0g. Citizen of V	Vhat Cour	ntry?
	3a or		48020 Freehold D	rivo		206	53		Unite	A C+	atos
	deatl	Funerai	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of Hill If Yes, specify Cubar	<del></del>	cify Yes or No-	14. Rac	e - Americ	can Indian,
21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. int: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow int: If yor other traumatic avent. The Modical Examinar must be muilled at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 No	Specify:	Rican, etc.)	Specify	ck, White, Wh	etc. ite
5	72 hc	Completed	15. Decedent's Ed (Specify only highest grad			dent's Usual Occupa		na	16b. Kind of Bu	ısıness/Ind	dustry
2	thin	npie	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired;	)	,,,g			
2	ygier ygier tt.	S	12			Clerical			Compute		
힡	be fit dott	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Sumam	e)	
3	ould Men Parke	2	James Mengel				Ida Ch				
Baltimore, Maryland	12 sh and d 7 is m		19a. Informant's Name/Relationship (7)			ng Address (Street a					·
e)	1 and 4ealth 9m 2 ther 1		Joan Turner / Dat 20a. Method of Disposition	ighter	20b. Place of Dispo	Freehold			n Park, 20c. Location -		
סר	ages in the fr		1 XBurial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other place	9) [				
Ē	it. Partimer ritant ritant		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Lines		1	Cemetery			Freebur		
Ba	permit. Page Depertment of Important: If any Injury or once.		Tolera Som	1		2. Name and Addres					
-			Edward N. Brinstie 23a. Part1. Enter the disease, or comp							MD :	20650-0279
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lin	10.	tor the mode or dying	g, sacri as caraiac c	respiratory and	631,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		r's Diseas	e					3 years
	Examiner			Due to (or as a	a consequence of):						
		e.		b. Cue to (or es a	a nonsequenne of):						
	uted d ansit	m in	cause. Enter Underlying Cause (Disease or injury								
Ć.	cate be executed obysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):						
8760,	re be ysicia e bur	dicai		d.							
9	tiffica ng ph as th	ledi							17.5		
Вох	The law requires that the death certific Ite has been signed by the attending p tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy				e of delive	эгу
E	deal	sicie	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant at		Other (specify)			Mor	ith	Day Year
<u>Р</u> О	that the de ed by the a detached f	Phy	9 Unknown								
	es tha	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in the u	nderlying cause give	n in Part I.				ne cause of death?
ord D	w requir been si should							1 □ Y€	s 2 No	3 Prob	ably 4 Unknown
Records,	law r as be	pie						24a. Was a autops		Vere autor	psy findings available mpletion of cause of
		Completed						perforr	ned?	leath?	
/ita	Attending Physician; The rideath. ector; After this certificate hiby the funeral director, page	Be (	25. Was case referred to medical examiner?				26. Place of Death	Check only on	9)		
<u></u>	Physi this c	2	1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatie			4A Nursing nor	ne 5□Reside	ence 6 □Othe	ər (Sp <b>e</b> cif)	v)
Ž.	After	inol.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	Work		28d. Describe ho	ow injury occurr	ed	
Sic	death ctor; /	cat	2 Accident investigation 3 Suicide 6 Could not be	District Control			′es 2 □No				
Division of Vital	ital or A rs after raf Direc led in by	Certification:	4 Homicide determined	building, etc				City or Towr	n, State)		il Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of mer: On the basis of and manifer sta	of my knowledge, deat examination and/or in ted.	h occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
	within 2.	Me	29b. Signature and tyle of certifier	1- /4//		29c. License	number	2	9d. Date signed	(Month,	Day, Year)
)			> // x/patt	TAIL	V MD	D 5	2196		8-7	-06	7
			30. Name and ddress of person who c	ompleted cause of de	eath (Item 23a) (Type,						
			JOhn Scott Tidbal			·	er, Calif	ornia,	Marylan	d 206	519
3	Sta	te	31. Date filed (Month, Day, Year)		r's Signature						
	Registr	ar	AUG - 7 2006	Se .	k dans.						
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	_	Registrar  Decedent's Name (Fig. 1)	irst, Middle, Last)	)	-		rtificate o			2. Date of De			3. Time of Death
cian lical	-	ALICE	STORMER							JULY	23 <sup>Day</sup>	2006	3:30AM M
iner	4.	a. Facility Name (If not HOMESTEAL		street and numb	er)		4b. City, Town		of Death			County of Death	!
l r		. Social Security Numb 218–26–494	6. Ser	х ]м 2 <b>%</b> F	Age (In yrs. 75	last birthday) Yrs.	If Under 1 Yea Months Day	ar If Unde	Min.	8. Date of Bir (Month, Da APR 4	th iy, Year)	9. Birthr	placa (State or Foreign
	_	Usual Residence of Dec 0a. State 10	b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
ctor		MD	CAROL	INE		DEN							1 XYes 2 No
Funeral Director	1	0e. Street and Number 410 COLON		RТ			10f. Zip Code	629			10g. Citiz	en of What Coul	ntry?
nera	1	1. Marital Status		12. Was Decede		.S. 13.	Was Decedent o		rigin? (Spe	cify Yes or No	p- 1	4. Race - Americ Black, White,	
2	5	1 Never Married 3 Widowed 4	Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	No		1□Yes <b>X</b> □N	lo Specify				Specify: W	HITE
ojete	_	(Specify o	Decedent's Edu only highest grad	e completed)		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during mo	st of worki	ng	16b. Kin	d of Business/In	dustry
Completed		Elementary/Seconda 12	ary (0-12)	College (1-4	or 5+)	NUR	SES AIDE	2			HOM	E_HEALT	H_CARE
Be	1	7. Father's Name (Firs	· ·							(First, Middle	, Maiden S	Sumame)	
2		GEORGE BU		rpe, Print)		19b. Maili	ng Address (Stre			WEAVER I Route Numb	er, City or	Town, State, Zip	code)
		DENISE LY	ONS/DAU	GHTER		2446	1 FRIEND	SHIP	ROAD,	PRESTO	ON, M	D 21655	
	2	0a. Method of Disposit 1 🛣 Burial 2 □ C		Removal from St	ate c	emetery, crei	osition (Name of matory or other p			ate		ation - City or To	
	_	` 4 Donation 5 □	Other (Specify)		WOO		MEMORIA 2. Name and Add			7/2006	EAS	TON, MAI	RYLAND
	-		and R		. = .0	$\sim \mathrm{F}$	ET.T.OUS.	HRI.RE	NRFIN	& NEW	IAM F	UNERAL 1	HOME PA
		mmediate Cause (Fina disease or condition resulting in death)		ne cause on each	h line.	ic a	ter the mode of d				rrest,	5.6.5006	Approximate Interval Between Onset and Death
Ical Examiner	or or or or or or or or or or or or or o	disease or condition	ions, diata	Due to (or	th line.	uence of):					rrest,		Interval Between
cai	or or or or or or or or or or or or or o	disease or condition resulting in death)  Sequentially list condition any, causing to immoduse. Enter Underlying ause. Enter Underlying ause (Disease or injurat initiated events	ions, diating fry	Due to (or  Due to (or  Due to (or  Due to (or  Due to (or  Due to (or  Due to (or	as a consequence of pregnant at time of distance of the consequence of	uence of):  uence of):  uence of):		a st				3d. Date of delive	Interval Between Onset and Death
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DHMH 17 Rev 1/2001

ORIGINAL

John

5 Social Security Number

4a. Facility Name (If not institution, give street and number)

Genesis HealthCare

Henry

12 M 2□F

Singletary

250-28-7303 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or items 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 610 Duchman's Lane 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ā 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unk. Maintenance 17. Father's Name (First, Middle, Last) Be ပ Singletary 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Importent: If item 27 Is any injury or other treuonce. Jack Singletary / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

1 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 07-31-2006 21. Signature of Funeral Service Licensee ammie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner osquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy performe 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certified Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Inpatient ٥ 1 🗌 Yəs 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural 5 Pending investigation 1 Tyes 2  $\square$  No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 20a) (Type, Print) (ROWLEY WD 610 MICHAEL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 8 2006 Registrar DHMH 17 Rev 1/2001

Certificate of Death Reg. No 2. Date of Death 3. Time of Death Month Vear July 2006 6:53 PM 25 Singletary 4c. County of Death 4b. City, Town, or Location of Death Talbot The Pines Easton Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours Months 10-04-1926 North Carolina 10d. Inside City Limits 1. Yes 2 No 10g. Citizen of What Country? IISA 14. Race - American Indian, Black, White, etc. Specify. Black 16b. Kind of Business/Industry Glenwood Elementary School 18. Mother's Name (First, Middle, Maiden Surname) Lillie Singletary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 165 Scott-town Road, Queenstown, Maryland 21658 20c. Location - City or Town, State Dover, Delaware 22. Name and Address of Facility funeral Home Bennie Smith funeral Home 426 Dover Street, Easton, Maryland 21601 Interval Between Onset and Death months 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 No

Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] [ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Thelma Jane Simpson 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL MEDRAL CENTER SALISBUIL Micimica PENINBULA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day Year) 4/11/1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2 F Days Hours 222-24-6231 67 Director Delaware Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than \*natural\*, or iteme 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be putified at once. Maryland Wicomico Director Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Creekside Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Š Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jesse C. Draper Helen Baker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D. William Simpson/husband 215 Creekside Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wicomircommentorial 1 ☐ Kurial 2 ☐ Cremation 3 ☐ Removal from State 8/3/06 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Dicenses PHOTIOWAY FURETAL Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a Part. Enter the disease, or complications that caused the death: Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician aver Lung /Medical Due to (or as a confequence of): Examiner prey wow s Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes or nyary that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? jo Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I certificate has been signed by the a rector, page 2 should be detached it 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2□ No 1□ Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Chack unity one) 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nakan 147094

Registrar DHMH 17 Rev 1/2001

State

1415 5. DIVISION

32. Begistrar's Signature

REPURE S

Street

544560y nd 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nakeyen

Vel

31. Date filed (Month, Day, Year) AUG 0 2 2006

		epartment of Health and Mental H Certificate of Death	lygiene 0 0 6 25950 Reg. No.
Physiciar	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day Year
/Medica Examine	MICHAEL DONALD TAYLOR	4b. City, Town, or Location of Death	23 2006 12.05 M
Examine	3410 Rhode Island Avenue	Mount RANIE,	a Prince 6 eogs's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min. (Month,	Day, Year) Country)
Director	Usual Residence of Decedent	APR. 2	28, 1942 WASHINGTON, DC
yland Mow	10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
vith the Maryland of contract of the motified at	MD PRINCE GEORGES MOUNT	RANIER	XX Yes 2 □ No
with th	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
offer death viller feme 23s	3410 RHODE ISLAND AVENUE #3  11. Marital Status 12. Was Decedent Ever in U.S.	20712  13. Was Decedent of Hispanic Origin? (Specify Yes or	UNITED STATES  No- 14. Race - American Indian,
1215-0036 within 72 hours eiter death with the Maryland ene. than "natural", or iteme 23s or 28s-1 show its Mudical Exercities Exactly to incide at models by Europeal Directory		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes XX No Specify:	Black, White, etc.  Specify: BLACK
Maryland 21215-0036 at 2 should be filed within 72 hours eff the and Mental Hygiene. 27 is marked other than "natural", or treumatic event, if a Medical Exact To Be Completed by E	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
21215-00 ed within 72 ho ygiene. Per then "natura it, if a Medical	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	DDTWAME
ind 212 be filed withing tal Hygiene. d other than event, it a M	UNK •  17. Father's Name (First, Middle, Last)	HOME IMPROVEMENT  18. Mother's Name (First, Midden)	PRIVATE  lle, Maiden Sumame)
/land /land wild be fil Mental H wrked out	PERCY TAYLOR	MARY SUTTON	
re, Maryland 212- s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than other treumstic event, ILAM	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rural Route Num	
	Mic St 2	02 RHODE ISLAND AVENUE #2 Disposition (Name of Date	
Saltimore, vermit. Pages 1 ar appartment of Heamportent: if Item my Injury or othe Ince.	XXBurial 2 □ Cremation 3 □ Removal from State cemetery	r, crematory or other place)	20c. Location - City or Town, State
Baltimor permit. Pages Department of Importent: If It any Injury or o	' 4 □Donation 5 □ Other (Specify) LINCOLN  21. Signature of Fuperal Service Licensee		
Balt permit. Depart Import any Inj	J. F. Maull	MARSHALL S FUNERAL HOME 4308 SUITLAND ROAD SUI	E OF MARYLAND, INC. TILAND, MD 20746
Physician /Medical	23a. Part 1 Finer the disease, or complications that caused the death. Do no shock, in heart failure. List only one cause on each line.  Immediate dause (Final disease or condition resulting in death)  a. At Lovo S C C Due to (or as a consequence of the conseq	rotic Cartlovescu	Interval Between Onset and Death
Examiner		<i>j.</i>	
executed n and ial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	n):	
8760, sate be executed thysician and the buriat-transit	that initiated events c. Due to (or as a consequence o	f):	
cate be excate be exphysician at the burial			
	IF FEMALE:		
The law requires that the death certific the has been signed by the attending page 2 should be detached for use as completed by Dhysic lay Mag.	23b. Was decedent pregnant in the past 12 months?  1	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year
Vital Records, P., sicien: The law requires that it certificate has been signed by rector, page 2 should be detained by Dr.	Tank it. Sense significant contained to contributing to death but not resulting in		d tobacco use contribute to the cause of death?  Yes 2 \( \sum \) No 3 \( \sum \) Probably 4 \( \sum \) Hinknown
I Record The taw requir		24a. W	topsy prior to completion of cause of
		pe 1 Tes	rformed? death? 2  No 1 Yes 2 No
Vital	axaminar?	26. Place of Death (Check onl	
hy hy h	1 Impatient 2 EH/Out	2.5.434	sidence 6 Other (Specify) se how injury occurred
in Signal	2 Accident investigation 3 Suicide 6 Could not be determined elemined building, etc. (Specify)	m, street, factory, office 28f. Location	n (Street and Number or Rural Route Number, Town, State)
Hospi 14 hou 15 fill 16 fill			
To the To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	forwarder / sprinter Do	40053927	July 25, 2006
7	30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)	boal usula.
State	31. Date filed (Month, Day, Year) 32. Registrar's Signapare	1005 p, 100 Jane C	- President
Registra	1111 2 X /11136		

			1 - For State Registrar	State of Man	yland / Depa <i>Cer</i>	irtment of H tificate of L	ealth ar D <i>eath</i>	nd Mei	ntal Hygie Reg		)6	25951
1	No.		1. Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day	rear	3. Time of Death
	Physici /Medio		Ruth Gertrude	Thomas							06	4:15 P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of	Death		4c. County of	Death	
			Holy Cross Hos	spital			ilver				onte	gomery
	Funeral		5. Social Security Number 6. Sec	7. Age (//	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day, Y	ear)	9. Birthp	lace (State or Foreign
	Director		101-40-2432	100 200	56 Yrs.			Se	ep. 6, 1	1949	Nev	v York
	and and		10a. State 10b. County	16	Dc. City, Town or Lo	cation					1	0d. Inside City Limits
	f sho	ō	Maryland Prince (	Connella		D.	. 1 1					1∭ Yes 2 No
	28a-	Director	10e. Street and Number	seorge s		10f. Zip Code	verda1	_e	10g	. Citizen of Wh	at Cour	itry?
	3a or		6008 Somerset	Road			207	137		Uni	tod.	States
	death ms 2	Funeral		12. Was Decedent Eve	or in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba			y Yes or No-	14. Race	Americ	an Indian,
9	or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No		_		Puerto Ric	an, etc.)		White,	
8	ral', c	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐ Yes 2 X No	Specify:			Specify:	E	Black
5	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tha Macical Exerciper mast by notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	ent's Usual Occupa	urina most o	of working	16	b. Kind of Busi	iness/Ind	Justry
7	of thin	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired,	)	3				
2	lygier her ti		12th			Sales C					ivat	e
Maryland 21215-0036	tall H	Be	17. Father's Name (First, Middle, Last) William Hill	Brazant Cr			18. Mothers		irst, Middle, Ma.	· ·		
2	J Mer nark	ှင							Edythe S			
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at ODGE.		19a. Informant's Name/Relationship (Ty	,		g Address (Street a				400.000	C1 2000 - 31	27.00
e) O	1 and Heelt em 2 ther		Dominique Thomas 20a. Method of Disposition		20b. Place of Dispos	08 Somers sition (Name of	set Ro	ad, B	iverdal	c. Location - C	207	37
altimore,	ages or o		1X Burial 2 ☐ Cremation 3 ☐ P	lemoval from State	cemetery, cren	atory or other place	3)					
를	rtant rtant njury		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Harmony M	emorial I			TORGON POTENTIAL TORGON	Lando		
Ba	Departimbo Impo eny i		21. Signatur of Foreign Service Electrist	Town IT	TII 22		•		wart Fu			
			23a. Part1. Enler the disease, or compli	ications that caused th	death Do not ente				I., NE W		DC	20019 Approximate
			shock, of heart failure. List only or	ne cause on each line.				ardiac or re	sspiratory arrest	,		Interval Between Onset and Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1	tatic Liv	er Cancei	-					
	Examiner			Due to (or as a co	onsequence of):							
		40	Sequentially list conditions,	Due to (or as a or	or/sequence of):							
	uted Insit	ul u	day, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	exect n and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						-	
8760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical		1								
89	ificati g phy as the											-
ŏ	leath certific	Iclan/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p						23d. Date	of delive	ery
. Box	deatl	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ 4 Pregnant at tim		Ectopic pregnancy Other (specify)				Montl	า	Day Year
O.	of the de by the a	hys	9 Unknown	9□ Unknown								
œ.	res the igned be dei	by Phys	Part II. Other significant conditions con	tributing to death but n	ot resulting in the ur	derlying cause give	n in Part I.		23e. Did tobac	co use contrib	ute to th	e cause of death?
Ë	w require been sig should b								1 🗆 Yes	2 □ No 3	☐ Prob	ably 4 □Unknown
Records,	aw re s ber 2 sho	plet							24a. Was an	24b. We	re auto	psy findings available apletion of cause of
ŭ	The lay	Completed						_	autopsy performed	d? de	or to cor ath? ]Yes	
Vital	iicien: Th certificete rector, pag	0	25. Was case referred to medical			1	26. Place of	of Death (C	1 Yes 2ty heck only one)	No 1L	1 1 65	20 140
	ysicien: is certific director.	ToB	examiner? 1 ☐ Yes 2 ₩ No	lospital:	2 ER/Outpatien	3□ DOA Othe			5 Residenc	e 6 Other	(Specify	()
Division of	Attending Physicien: r death. ector: After this certifici by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work			. Describe how			
Ö	endir ath. or: Af	atle	1		,,		es 2□No	0				
ž	r Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	et, factory, office		28f.	Location (Stree City or Town, S	et and Number State)	or Rura	l Route Number,
	rs afte rs afte ra Dir led in I	Cer										
	To the Hoepital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	cal	(Check only 2 Medical Examin	sician: To the best of m	ny knowledge, death amination and/or inv	occurred at the tim	e, date and printed	place, and	due to the caus	e(s) and mann	ner as st	ated.
	the P nin 24 the F tylete	Medical	one)	and manner stated	1.							
	To vit	~	29b. Signature and title of certifier	MATTAI	MAL	29c. License		70	29d.	Date signed (		
				1001000			DR635	/ 7		July	23,	2006
R	(4)		30. Name and address of person who co	-					_			
L			Ram Trehan,	M.D. 150	0 Forest	Glen Rd.,	Silve	er Sp	ring, M	D 2091	0-1	484
	Sta Registr		JUI 2 8 2006	Electer.		,						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Guy Lewis Tuel, Jr. 30, July 2006 12:45 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 904 Philadelphia Ave. Mountain Lake Park Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F 577-20-1232 85 Yrs Director Apr. 4, 1921 Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Exemples, but be notified at Director 1KYes 2 □ No MD Garrett Mountain Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 Philadelphia Ave. 21550 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examilier. 1991, 0068. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Gas Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy Lewis Tuel, Sr. Elizabeth Τ. Bettis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Velma M. Liller/Wife 904 Philadelphia Ave., Mountain Lake Park, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Rocky Gap MD Vets Cem. 8/3/2006 4 Donation 5 Other (Specify) Flintstone, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD 21550 cosy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physicien and should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes autopsy performed? 1 Yes 2X No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending within 24 hours after death. To the Funerel Director: A М 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Quel Danie H26154 7/31/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10+VA

Division of Vital Records. P.O. Box 68760.

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG - 2 2006

Dr. Paul D. Miller MD

State

Registra

69 Wolf Acres, Oakland, MD 21550

			1 - State of Maryland / Department of He State of Maryland / Department of He Certificate of E	Death	Reg	ene2 () () ()	25953
	Physicia	an	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	/Medic		Martina Harris Turner		07 24	2006	2130 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death		4c. County of Deat	h
			Anne Arundle Hospital Annapo			Anne Arur	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min.	<ol><li>Date of Birth (Month, Day, Y</li></ol>	ear) 9. Birti	hplace (State or Foreign untry)
	Director		213-22-9437 88		06-05-19	18 Mar	yland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	/anyl	ō					1 Yes 2 No
	28e-1	Director	Maryland Queen Annes Stevensville  100. Street and Number 10f. Zip Code		100	. Citizen of What Co	
	with a or	ā			1.09		unity s
	eath	Funeral	302 Lots Road 21666  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His		oify Vee or No-	USA 14. Race - Ame	rican Indian
	ter d Item	Ë	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Ves 2 2 No	n, Mexican, Puerto F	Rican, etc.)	Black, White	
36	rs af	by F	If Yes, Give 1 ☐ Yes 2 ☑ No Year or Dates:	Specify:		Specify:	1 1-
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "naturel", or Items 23a or 28e-f show snt, the Modical Examiliational be notified at	ed	15. Decedent's Education 16a. Decedent's Usual Occupal	ation	16	b. Kind of Business/	Lack Industry
7. 13.	n "ng	Completed	(Specify only highest grade completed) (Give kind of work done do	luring most of workin	ng		,
7	iene.	lmo	Elementary/Secondary (0-12) College (1-4or 5+)  6 Home maker		9.0	ome one e	lse's home
D	Hyg othe ent.	Be C	Tomo marter	18. Mother's Name			IBC D HOME
a	ld be ental ked i	To B	Charles Harris	Mary	Gross		
Ž	shou nd M mar imet	_	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street all</i>			ity or Town, State, Z	Tip Code)
Maryland	nd 2 lith a 27 is r treu		Charles Turner / son 17 Whitehorse	Drive R	arlin M	ruland 2	1.9.1.1
	Hea Hea tem othe		20a Method of Disposition 20b. Place of Disposition (Name of	Da		c. Location - City or	
no	ages int of t: if i		1 Magurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Cemetery, crematory or other place  Cold Love Point Cerematory	1	2006	Storron arri	llo Mawriand
Baltimore,	artme orten injury		21. Sin Tu F neral Service Licensee 2 22. Name and Address		-2006	stevensvi.	lle,Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumetic event. Ite Modical Examiner must be notified at 2000.		Bennie Smi 426 Dover	ith Funera r Street,			
			23a. Plant Lenter the disease, or complications that caused the death. Do not enter the mode of dying sheck, or heart failure. List only one cause on each line.	g, such as cardiac or	r respiratory arrest		Approximate Interval Between
H	Pnysician		Immediate Cause (Final disease or condition				Onset and Death
Н	/Medical		resulting in death)  Due to (or as a consequence of):				
п	Examiner		Sequentially list conditions, b. Long Canal				
	p #	ner	if any, leading to immediate cause. Enter Underlying Cause University (Disease of mijury				
	nd rrans	Examiner	that initiated events c.				
Ö,	e exe	Ë	resulting in death) Last Due to (or as a consequence of):			İ	
8760,	ate be executed thysician and the burial-transit	licai	d				
Ó	ng p as	Physician/Med	IF FEMALE:			-1	
Вох	that the death certifi ed by the attending I detached for use as	an/l	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of deli	very Day Year
	ne dea the at hed fo	sici	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Teal
P.0	at the	hy	9 Li Unknown				
	res tha igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gives	on in Part I.		co use contribute to	
ord	w requir been si should	ted	Chronic Obstructive tulnanory Discesse,		1 ∐ Yes	2 ∐No 3 ∏Pro	obably 4 Unknown
Vital Records,	ie ław r has be ge 2 sh	Completed by	Chronic Obstructive Sulmanary Discase, Coronary Artery Discase		24a. Was an autopsy		topsy findings available completion of cause of
ř	The transparence of transparence of the transparence of transparence of transparence of transparence of transparence of transparence of transparen	шо			performer	d?   death?	_
ţa	ilcien: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death			
	Attending Physicien: ir death. ector: After this certifica by the funeral director.	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	or: 4 ☐ Nursing Hom	ne 5 🗆 Residenc	e 6 □Other (Spec	cify)
Division of	g Physier this		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury Work' (Month, Day Year) Injury Work'		8d. Describe how		
<u>o</u>	ittending F death. ctor: After / the funer.	Certification:		res 2□No			
Vis	or Attendate death Director:	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
Ö	el or A s after of Direct	Sert	Tronned Building, etc. (Specify)	4	ony or rown, c	naie)	
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time				
	24 ne Fu	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opione) and manner stated.				to the cause(s)
	To the To the To the Comp	Me	29b. Signature and title of certifier 29c. License	number	29d.	Date signed (Month	n, Day, Year)
•			I P 11 Little MS	161825		7/25/	2006
	//		29b. Signature and title of certifier  29c. License  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Reynalds (ee (Icen II n) 2108 Di Donch Death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Register's Signature  JUL 2 8 2006	-/		1 /	
	15		Reynolds Lee - Claser II mg 2108 Di Donato D-	Chair	tre - MI	21615	
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	1		, -1011	
	Registr		JUL 2 8 2006				
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			State Registra Amend item 3	State of Maryla per wichd/	.nd / Depai <b>8-2-06∉</b> /₫	rtment of F <b>Tis</b> ate of	lealth and N <i>Death</i>	_	giene Reg. No.	6 25954
	sicia	ın	1. Decedent's Name (First, Middle, Last) Rebecca Lee	Taylor				2. Date of De Month July	Day \	7ear 9:05 M
	edic imin		ta. Fecility Name (If not institution, give so 6041 Hunters Mill				r Location of Death		4c. County of	
Fune Direc			5. Social Security Number 6. Sex		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bird (Month, Da 8/07/.		9. Birthplace (State or Foreign Country) irginia
yland	4		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Loca	ation				10d. Inside City Limits
e Mar	PALL	ctor	Maryland Wicomico	)	Salisbu	ry				1 ☐ Yes 2X No
with th	200	I Dire	10e. Street and Number 6041 Hunters Mill	Drive		10f. Zip Code 2180	01		10g. Citizen of Wh	nat Country?
DESILITION E.) INICITY INICITY OF THE STANDARD PERMIT. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!; or Items 23a or 28a-f ehow	ANT DE BET THE	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ₩idowed 4 □ Divorced	2. Was Decedent Ever in Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	ł	as Decedent of H Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc. White
72 hou	a la contra	Completed	15. Decedent's Educ (Specify only highest grade	ation	(Give ki	nt's Usual Occup ind of work done O NOT use retire	during most of world	king	16b. Kind of Busi	iness/Industry
d withir giene.	IN BUI	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		etary			Governm	ent
be file	event	Be	17. Father's Name (First, Middle, Last)  Grady Lee Nixon			-		ae (First, Middle, Leone Ne	, Maiden Sumame) alson	)
hould Mer	matic	٥.	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing	Address (Street	and Number or Ru			tate. Zip Code)
ind 2 salth an 27 is	ar trau		Donna Meeks/daught				ce Dr., S			
Pages 1 and Hermit: If item	ry or othe		20a. Method of Disposition 1 □ <b>X</b> eurial 2 □ Cremation 3 □ Re 1 □ 1 □ 1 □ 2 □ Cremation 3 □ Re	moval from State 20b.	Place of Disposicements, cremetery, cremetery. Cennet	tion (Name of atory or other plan Nation erv	al 8/1	Date 7/06	20c. Location - C	
permit. Pages Department of Important: If it	any inju		21. Signature of Funeral Service Lice	2	Ho	Name and Addre		ome Proi	fessional	Association
_			23a. Parri. Enter the disease, or complice stock, or heart failure. List only on	ations that caused the de						Approximate Interval Between
Pnysic /Medi	cal		Immediate Cause (Final disease or condition resulting in death)	1 5	seatic	CC	ince	اسا		Onset and Death
Exami	ner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Lisease of it jury	Due to (or as a conse	equence of):					
xecuted	al-transit	Examiner	cause. Enter Underlying Causes (Lisease or it jury that initiated events resulting in death) Last  c.	Due to (or as a const	equence of);					
ficate be executed physician and	the buri	edical E	d.							
certi	ched for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of preg 1 DLive birth 2 DFe 4 Pregnant at time of 9 Unknown	etal death 3 DE	Ectopic pregnanc Other (specify)	y		23d. Date Month	
The law requires that the death	uid be deta	ρλ	Part II. Other significant conditions conf	ributing to death but not re	esulting in the und	derlying cause giv	ven in Part I.	23e. Did t		ute to the cause of death?  Probably 4 Unknown
The la	oage z	completed						24a. Was autor perfo	osy pri	ere autopsy findings available or to completion of cause of ath?
VIICA ician:	ector,	BeC	25. Was case referred to predical examiner?	ospital:		Ott	26. Place of Dea		one)	
Phys	aral dir	Į.	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injur	ner: 4 Nursing H	_	dence 6 Other	
Attending at death.	e rune	atlor	1 Accident 5 Pending investigation	(Month, Day Year)	Injury	Wo	rk?  Yes 2 □No			
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director After this certificate has	ad in by tr	Certification;	3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stree cify)	et, factory, office		28f. Location ( City or Tox		or Rural Route Number,
e Hospit	letely fills	edical		ician: To the best of my k er: On the basis of exami and manner stated.						
To th Withir To th	comp		29b. Signature and title a periffer	(h) '''	COH	29c. Licens	se number	22	29d. Date signed (	Month, Day, Year)
1000			30. Name and address of person who con			rint)	alich	on	MA	21801
Re	Sta gistr		31. Date filed (Month, Day, Year)	32. Registrar's Sig 0 2 2006	mature	4 Span	les .			

			1 - For State Registrar	State of Marylar			t of Health and e of Death		giene	006	25955
	Physici		Decedent's Name (First, Middle, La     ERWIN HERMAN	•	UMBACH			2. Date of Dea	30°,	2006	3. Time of Death 9:50P M
	/Medic Examin		4a. Facility Name (If not institution, given 311 APPLE GROVE				Town, or Location of Di			ounty of Death	RY
Ī	Funeral Director		117 11 1707	7. Age (In yrs. 84		If Under Months		Hrs. 8. Date of Birt Min. MAY II	192	9. Birthr 2 OKL	olace (State or Foreign AHOMA
	after death with the Maryland or Iteme 23e or 28e-f show other name be notified at	i Director	Usual Residence of Decedent  10a. State 10b. County  MARYLAND MONTGO  10e. Street and Number  311 APPLE GROV	MERY	ty, Town or Lo	SPRI 10f. Zip			_	n of What Cou	10d. Inside City Limits 1 □ Yes 2√√√√ No  ntry?  OF AMERICA
2-003b	hours after death turel', or Iteme 2:	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 → Yes 2 → No If Yes, Give Year or Dates: 1942		Was Deced If Yes, spec	lent of Hispanic Origin? ify Cuban, Mexican, Po No Specify:	(Specify Yes or No- uerto Rican, etc.)		Race - Americ Black, White, pecify:	
7-61212	ed within 72 h giene. er than "natu ", ise Med Fal	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)		(Give	kind of wor DO NOT us	OFFICER		CENT	AGENCY	dustry ELLIGENCE
yland	ould be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last ERWIN T. UMBA					Name (First, Middle, STIEGEME)		umame)	
more, mar	nit. Pages 1 and 2 should artment of Heelth and Mer ortent: If Item 27 is marke Injury or other traumatic is.		19a. Informant's Name/Relationship ( CORWIN P. UMBACH  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	- SON 20b. I	1600 Place of Disponentery, cre	SOUTH osition (Name matory or of	ther place)		7N, Al 20c. Loca	RLINGTO	N, VA 22202
Baitin	permit. Pa Department Important any Injury		4 Donation 5 Other (Special Service Lice	y)	2:	2. Name an		HINES RINA	ALDI 1	FUNERAL	HOME, INC.
8/60,	Physician /Medical Examiner  Physician and pural-transit it is partial transit.	dicai Examiner	23a. Part VEnter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect to the deal one cause on each line.  a. Due to (or as a consect to the deal one cause on each line.  Due to (or as a consect to the deal one cause on each line.	quence of):		e of dying, such as can which as can teny D	0.0	rest,		Approximate Interval Between Onset and Death
C. BOX 6	the death certificate be ev y the attending physicien ched for use as the buria	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3[	⊒Ectopic pro ⊒ Other (sp.			23	d. Date of delive Month	ery Day Year
ras, P.	law requires that the de as been signed by the 2 should be detached	ρ	Part II. Dther significant conditions	contributing to death but not res	sulting in the u	inderlying ca	ause given in Part I.	23e. Did to			he cause of death?
Vital Record	The lay ete has page 2	Completed						1 ☐ Yes	med?	24b. Were auto prior to co death? 1  Yes	ppsy findings available mpletion of cause of
5	Phy this	Certification; To Be	25. Was case referred to medical examiner?  1  Yes	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 2	8c. Injury at Work?	Death (Check only of grand of the second of	dence 6 [	pecurred	
2	To the Hospital or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funer		4 ☐ Homicide determined	building, etc. (Speci	fy)  wledge, deat	th occurred	at the time, date and pl	City or Tov	vn, State)  cause(s) ar	nd manner as s	al Route Number,
	To the Holl within 24 h To the Fur completely	Medicai	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	ation and/or in	vestigation,	in my opinion, death o	ccurred at the time,	date and p	lace, and due to	o the cause(s)
	20		30. Name and address of person who		10 m 23a) (Type,	Print)	D 00079	66	8	1106	20912
	Sta Registi		31. Date filed (Month, Day, Year)	32 Megistrar's Sign	ature &	cili	D 000 17	come Th	K, W	10 2	

			1 - For State Registrar	State of	f Marylar		artment <i>rtificate</i>			nd Me		giene Reg. No	/ 111	) 6	259	56
	Physici /Medic		1. Decedent's Name (First, Middle, Eunice Ora Wi								2. Date of De Month July	Da	<sup>y</sup> 2006	/ear	3. Time of Dec	ath M
<i>j</i>	Examir		4a. Facility Name (If not institution, Southern Maryla 5. Social Security Number	nd Hospit			4b. City, To	intor			8. Date of Bir	I	County of	e Geo		
	Funeral Director		118-20-6491 Usuat Residence of Decedent	1 □ M 2 🂢 F	79	Yrs.	Months I		Hours	Min	(Month, Da	v Vear	926	D. C	ace (State or Fo	ireign
	ith the Marylar or 28a-f ehow	Director	MD Prince  10e. Street and Number  11602 Mary Cath	Georges	C]	inton	10f. Zip C					_	tizen of Wh	at Count	od. Inside City L  1  Yes 2  try?	
350	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event, its Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Dece Armed For	dent Ever in Urces?			nt of Hisp y Cuban,	anic Origi Mexican, Specify:	in? (Spec Puerto R	cify Yes or No lican, etc.)		S. A  14. Race - Black, Specify:	America White, a	etc.	
9500-61212	ad within 72 hou giene. er then "natura , the Medical E	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education		(Give	dent's Usual ( kind of work DO NOT use	done dur.	on ing most o	of workin	g	16b. K	ind of Busi	ness/Ind	ustry	
yland	2 should be filed and Mental Hygie I marked other raumatic event, II	To Be (	17. Father's Name (First, Middle, L James Albert S	prings					Ell	a Da	(First, Middle, niels					
_	and 2 shi lealth and m 27 le m		19a. Informant's Name/Relationsh Gwendolyn Scott			1925	Cumber	cland		., P	Route Number etersb	urg,	VA 2	23805	5	
IIIIIOLE	t. Page ntment o rtsnt: If njury or		20a. Method of Disposition  1 X Burial 2 Cremation 4 Donation 5 Other (Sp  21. Signater of Funeral Service).	ecify)		Place of Dispondentery, cremetery, cremetery, cremetery, cremeters	am Vet	. Cer	1		2006	Che.	ocation - Ci ltenha	am,	MD	
Dair	Depariment Department of the process		23a. Part 1. Enter the disease; or spock, or heart failure. List of	Sourse	aused the deat		03 OTO	l Bra	inch .	Ave.	, Temp	le E	on Fu	MD	al Home 20748 Approximate	, P.
,	The law requires that the death certificate be executed XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	STR or as a conseq	Uence of): PEL uence of).	<u>-</u>								Interval Between	
.C. BOX 0	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of d	I death 3	Ectopic preg Other (speci						23d. Date of Month		y Day Year	
cords, r	equires that en signed b buld be deta	þ	Part II. Other significent condition	s contributing to dea	ath but not res	ulting in the ur	nderlying cau	se given i	in Part I.		23e. Did to		_		e cause of death	
	r. The law r licate has be r. page 2 sh	Completed											prio	r to com th?	sy findings avail pletion of cause 2 No	lable of
NA IO HOISIA	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigations.	28a. Oate of (Month		ER/Outpatien 28b. Time of Injury		Other: Injury at Work?	4 ☐ Nurs	sing Home	Check only one 5 ☐ Resided. Describe h	lence		(Specify)	·	
	Ital or Atters after destal Directo	Certification:	3  Suicide 6  Could no 4  Homicide determin	ned 28e. Place of buildin	of Injury - At ho g, etc. (Specif	·)					City or Tou	vn, State	)		Route Number,	
	the Hosp nin 24 hou the Funer npletely fil	Aedical	one) 2   Medical E	Physicien: To the taxaminer: On the baxaminer and manner	sis of examina	wledge, death tion and/or inv	estigation, in	my opini	on, death	place, an occurred	d at the time, o	date and	l place, and	due to t	the cause(s)	
•	F M C oo	×	29b. Signature and title of certifier	8040				icense ni	-812 numper	8			e signed (A		2006	
K	(3)		30. Name and address of person w	6192 DX0	JIH W	LROA	52 H C-	00	OXON	1111	u m	0	2076	15		
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 0 1 200	6 Section	gistrar's Signa	Local	2									

			For State Registrar	State of	Maryland / Depa	artment of F		_	giene Reg. No. 2	06	25957
· No.	* * * * * * * * * * * * * * * * * * *	1 2	Decedent's Name (First, Middle)	, Last)				2. Date of De Month		Year	3. Time of Death
16	Physici /Medic		Clara Rosa	Weddle				July		006	9:56 P M
	Examin	14 4	4a. Facility Name (If not institution,			4b. City, Town, o			4c. County		
. 9	15. ja		Prince George		:al '. Age (In yrs. last birthday)	If Under 1 Year	Cheve	-			George's
	, Funeral Director		5. Social Security Number  228-54-4422	1 □ M 2 □XF	68 Yrs.	Months Days	Hours	Min. (Month, Da	iy, Year) 1937	Cour	place (State or Foreign ntry) Virginia
Wat			Usual Residence of Decedent					pcc. 1,	1 1 1 1 1		
	urylan show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits 1 X Yes 2 □ No
	18a-1	Director		e George'	S	404 7:- C-4-	Lanha	am	10g. Citizen of	What Carr	
	with t	ā	10e. Street and Number 9975 Good I	uck Pond	#m2	10f. Zip Code	2070	16			States
	ns 23	Funeral	11. Marital Status	12. Was Deced		Was Decedent of h		in? (Specify Yes or No., Puerto Rican, etc.)	)- 14. Rad	ce - Americ	can Indian,
9	or iter	Ē	1 Never Married 2 Marrie	ed 1 Yes 2	2 (XNo	If Yes, specify Cub  1 ☐ Yes 2 🗓 No		, Puerto Rican, etc.)	Bla Specif	ck, White, Af	etc. rican
003	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f show the Madical Exerciper must be notified at	d by	3 ☐ Widowed 4 🏋 Divorced	Year or Da	les:					An	nerican
15-	"nat	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	16b. Kind of B	usiness/Ind	dustry
212	withi	mo	Elementary/Secondary (0-12) 12th	College (1-	4or 5+)	ocery Sto	,	ner	Self	-Emp1	oved
br	e filec al Hyg othe vent.	Bec	17. Father's Name (First, Middle, L		, , , , , , , , , , , , , , , , , , , ,		1	r's Name (First, Middle			
ylaı	Menta Menta Brked	10 0	Frank	Stewart				Beauty	Daugher	ty	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other then "naturel", or items 28a or 28a-f show other traumatic event, the Medical Expresser must be notified at		19a. Informant's Name/Relationsh					r or Rural Route Numb	-		
	jes 1 and 2 t of Health if item 27 or other tru	1	Valerie Merriw 20a. Method of Disposition	reather/Da	20b. Place of Dispo	osition (Name of	Ţ	1., #T3, La	innam, M		0706 own, State
Saltimore,	0 0		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from S	tate	matory or other pla	!	7/28/2006			
altir	그 된 본 글 .		21. Signature of Funeral Service			Cremator 2. Name and Addre			: Funera	inton	
ä	Depa Impo any is		lohn!	· Slewa	$X \cap X$	4001	Benn	ing Rd., NE			
- E			23a. Part1. Enter the disease, or shock, of heart failure. List of	complications that ca only one cause on ea	used the death. Do not en ch line.	ter the mode of dyl	ng, such as o	cardiac or respiratory a	rrest,		Approximate Interval Between
100	Physician		Immediate Cluse (Final disease or condition resulting in death)	_a. \\	situent	v b	bond	Lation			Onset and Death
	/Medical Examiner		resulting in dealing	Due to (d	or as a consequence of):	In the Man	man	572-774.			
	3 Single	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a consequence of):	www	, oug	puny			
	uted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C				S 20			
0,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Ex	resulting in death) Last		or as a consequence of):						
8760,	ohysic the bu	dical		d.						-	
ox 6	leath certifica attending ph for use as the	Me	IF FEMALE:	23c If yes outc	ome of pregnancy	V-50			024 D		
Bo	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 ☐ Fetal death 3[	☐Ectopic pregnanc ☐ Other (specify) _	У			ite of delive onth	Day Year
0	t the d by the achec	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknow	wn						
S, P	res that the de signed by the a be detached f	by P	Part II. Other significant conditio	ns contributing to dea	ath but not resulting in the u	Inderlying cause gr	ven in Part I.	23e. Did t	obacco use con		ne cause of death?
brd	w require been sig should b							1	Yes 2 No	3 Prob	pably 4 Unknown
Records,	e law r has be	Completed						24a. Was	DSV	prior to cor	psy findings available mpletion of cause of
								1 ☐ Yes		death? 1 ☐ Yes	2 No
of Vital		Be	25. Was case referred to medical examiner?	Hospital:	patient 2 ER/Outpatie	Ott Day Ott	han	of Death (Check only			
		n: To	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date o	Injury 28b. Time of	III JUDON	4 🗀 1901	sing Home 5 Resi	how injury occur		у)
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	9	n, Day Year) Injury		rk? ]Yes 2 □ N	40			
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 200. Place	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office		28f. Location ( City or To		er or Rura	al Route Number,
	pital c urs af srai D illed ir		on Cartain	- Dhusisian Taba							
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I	Medical	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the ba	best of my knowledge, dea sis of examination and/or ir er stated.	in occurred at the ti ivestigation, in my	me, date and opinion, deat	h occurred at the time,	date and place,	anner as si	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	(1) 6	$\bigcap$	29c. Licens	se number	2.0	29d. Date signe	d (Month,	Day, Year)
				try 0	ny	(	503.	59	(	11/2	-1/02
R	(3)		30. Name and address of person	the completed cause	of death (Item 23a) (Type	Print)	1, R	d # 31	2 de	uha	cu 191
1	Sta	ate	31. Date filed (Month, Day, Year)		gistrar's Signature	OC W	W W	7 7 7	1		20707
	Registi	rar 🏻	JUL 2 8 21	006	w A Spa	le					

		•	For State Registrar	State of Maryland / [	Department of Health and N Certificate of Death	fental Hygien Reg. N	21116 2	5958
	N		Decedent's Name (First, Middle, Lateral		O O / I / O O O O O O O O O O O O O O O	2. Date of Death Month D		Time of Death
	Physici /Medio		cullard	Webster		FU1 25	5006 0	210 M
	Examin	er	4a. Facility Name (If not institution, giv	street and number)	4b. City, Town, or Location of Death		Ic. County of Death アルカイマのか	10 4 Lan
	Funeral Director	*		ex 7. Age (In yrs. last bir		8 Date of Birth (Month, Day, Yea 5-12-36		(State or Foreign
	and w		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location		10d. In	nside City Limits
	Maryl	tor	MD MONTGO	MERY SILV	ER SPRING		ر <sub>ا</sub>	Yes 2□No
	or 28a	Olrec	10e. Street and Number		10f. Zip Code		Citizen of What Country?	
	s 23a	ral	601 EAST RANDOLP	Υ	20904		U. S. A.	diag
36	72 hours after death with the Maryland Inatural', or items 23s or 28s-f ehow dical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecry Yes or No- Rican, etc.)	14. Race - American Inc Black, White, etc. Specify: BLACK	Jian,
2-0	72 hours af 'natural', or dical Exem	eted	15. Decedent's En		Decedent's Usual Occupation (Give kind of work done during most of work	16b.	Kind of Business/Industry	,
21215-0036	ges 1 and 2 should be filed within 72 hc it of Health and Mental Hygiane. If item 27 Is marked other than "nature or other traumatic event, the Medical	Completed by	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+)	COUNSELOR	TR	RANSITIONAL I	HOUSE
Maryland	buld be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last, JOSEPH W. WEBSTE		RUTH RA	e (First, Middle, Maide ND	in Surname)	
ary	should and Men is marks	Ç	19a. Informant's Name/Relationship (		. Mailing Address (Street and Number or Run		or Town, State, Zip Code	a)
	1 and 2 s Health an tem 27 is		EMILY WEBSTERU		1 EAST RANDOLPH RD #	- university -		
Baltimore,	Pages 1 ar		20a. Method of Disposition  **XBurial 2	Removal from State cemeter	ry, crematory`or other place)		Location - City or Town, S	itate
Itim			4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		LINCOLN CEMETERY 7-3 22. Name and Address of Facility PIN		RENTWOOD, MD GLER FUNERAL	HOME
Ba	permit. Dapartr importe any inje		Theudou C	. Pinckney	524 - 8TH ST., N. E			a Management
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de th. Do one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Inter	roximate rval Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Probable	myocas da) 13	BArch	or Dr	nE
	Examiner		1	Due to (or as a consequence	on read C.	WCA		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	g():	/		
	and I-trans	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence	e mellit	US		
8760,	cate be executed physicien and the burial-transit	dical E		2 40 10 (0) 43 4 00/1304440/100	<i>51)</i> .			
9	tificate ng phy as the	Medic	JECCULE .	•				
.O. Box	The law requires that the death certific sie hes been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day	Year
Records, P.	quires that I n signed by uld be deta	þ	Part II. Other significent conditions of	contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco	o use contribule to the cau	use of death?
900	e law requir hes been si je 2 should	Completed				24a. Was an autopsy	24b. Were autopsy fir	ndings available
E B		Com				performed?	death?	
Vital	Physician: 1 this certificed ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)		
o		on: To	12 Yes 2 □ No  27. Manner of Death 12 Natural 5 □ Pending	28a. Date of Injury 28b.	Time of njury 28c. Injury at Work?	ome 5 Residence 28d. Describe how in		
Division	ten leat tor: the	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	B 280 Place of Injury At home to	M 1 □ Yes 2 □ No	28f. Location (Street and City or Town, Sta	and Number or Rural Rou ate)	ite Number,
J	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Ce	29a. Certifier 1 Certifying Pt	nysicien: To the best of my knowledge miner: On the basis of examination an	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	and due to the cause	(s) and manner as stated.	cause(s)
	thin 24 the F mplete	Medi	one) 29b Signature and title of certifier	and manner stated.	. 29c. License number		Date signed (Month, Day,	
	Z ≥ ₹ 8		an so	sex mom	12 6.57	ナし	/ 26 20.	
2	(10)		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print) 2101 med	1(a/ )2a	rk Dr	
	0		ILA N BKE	CHER MO ON	16 SILVEY GA	1127	mo 2090	24
7	Sta Regist		31. Date filed (Month, Day, Year)	22. Registrar's Signature	back			

			- F	For State Registrar			of Man	yland		artment rtificate			and M		Reg. No	711	06	25	959
	Physici	an			(First, Middle, La Corneli		htor	Tr						2. Date of De Month	ath Day		Year	3. Time of	
	/Medic	al			not institution, giv			OI.		4b. City.	Town, or	Location of	of Death	Hugus		County o	O G	8:40	77
	Examin	er			ton Coun					45. Ony,		gerst				Wash		ton	
	Funeral			cial Security Nu	mber 6. S	Sex	7. Age (/		st birthday)	If Under Months	1 Year	If Under Hours		8. Date of Bir (Month, Da	th			ace (State or	Foreign
	Director			4-09-22	08	I□M 2🂢 F		97	Yrs.	IVIORIUIS	Days	riours		Feb 5	190	9 1	Mary.	lánd	
	and w		_	Residence of I	10b. County		11	0c. City	Town or Lo	ocation							1	0d. Inside Cit	y Limits
	Maryl -f ehc	ţ	Ma	ryland	Washin	gton			Hager	stown								1 🗆 Yes	2 <b>X</b> No
	a or 28s	Funeral Director		Street and Num	ordon Ci	rcle				10f. Zip	Code 217	42			10g. Cit	izen of Wi	hat Cour	ntry?	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28s-f show any injury or other treumatic event, it a Modical Examinar must be multiled at ance.	à	1	Marital Status  Never Marrie	od 3/5 Married	Armed	Decedent Eve 1 Forces? es 2 No Give or Dates:	er in U.S	1	Was Deced If Yes, spec				ecify Yes or No Rican, etc.)	)-	14. Race Black Specify:	- Americ , White, Wh:	etc.	
5-0	72 ho	eted		(Special	15. Decedent's E	ducation ade complete	əd)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	il Decupa rk done d	ation furing mos	t of work	ing	16b. K	ind of Bus	siness/Inc	dustry	
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d 21	Hygie Hygie ther t		17. F	ather's Name (/	First, Middle, Lasi		4		OWI	ICT		18. Mothe	r's Name	e (First, Middle	1				
an	d be entail	To Be			Corneli		chter	Sr				-	īda 7	Auman					
Maryland	shoul nd M	-			me/Relationship		TICET_	OI.			-	and Numbe	er or Rura	al Route Numb	-				
Ž	elith a			Nan Mac	hey Wach	ter (v							cle H	Hagerst	own .	Mary.	land	21742	
ore	of He of Herr			Method of Disp	osition Cremation 3	Bemoval fro	om State	20b. Pla	ace of Disponentery, cre	osition (Nan matory or o	ne of ther place	Θ)	[	Date		ocation - C	•		
Ĕ	Pag ment ant: l		4	4 Donation	5 Other (Speci	fy)	Sin Giais	Ros		.1 Cem		-	Aug	5 2006	На	gers	town	Maryl	and
Baltimore	Depart Import eny in		21. 5	Signature of Fur	neral Service Lice	nsee	ing			2. Name an 331 E			DO	ıglas A N. Hag	. Fi erst	ery l	Fune: Mary	ral Ho land 2	me 1742
			23a.	. Part1. Enter th shock, or hear	e disease, or con vailure. List only	plications the	at caused thon each line.	e death	. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Bety Onset and D	veen
4	Physician		dise	ediate Cause (I ase or condition ulting in death)	Final	a. In	tra	abo	omi	nal	Sep	515						Onsot and t	
	/Medical Examiner		1030	nang in dealin	(	Due h/l	to (or as a c	upeano:		C .	,								
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ć	te be executed ysicien and e buriel-transit	Exa	resu	ilting in death) L	ast	Due	to (or as a	consequ	ence of):			- Cor			-				
120	ete be executed hysicien and the buriel-transit	Cal			•	d													
Box 68	es that the death certificete igned by the ettending phys be deteched for use as the	by Physician/Med		EMALE: . Was decedent in the past 12 i		1□Lh	outcome of ve birth 2	Fetal	death 3	⊒Ectopic pr						23d. Date Mon		•	'ear
0.	the de	ysic		1 ☐ Yes 2 ☐ 9 ☐ Unknown	]No		regnant at tin nknown	ne or de	atn 5	Other (sp	өспу)								
Δ.	requires that the een signed by th rould be deteche		Part	II. Other signifi	cant conditions	contributing t	to death but i	not resu	Iting in the (	underlying c	ause give	en in Part I			tobacco Yes 2		bute to th	ne cause of do	eath? Inknown
Records,	5 0 5	Completed												24a. Was	an	24b. W	/ere auto	psy findings	available
Re	The la ste hes cage 2	E G													ormed?	de	eath?	psy findings a mpletion of ca 2 No	use of
ta	en: T	0		Was case referr	ed to medical	T						26. Place	of Deat	1 ☐ Yes	2☐Mo one)	2 ''		20 100	
Ž	Physician: this certific ral director,	To B		examiner? 1 ☐ Yes 2 ☑1	No	Hospital: 1	Inpatient	2 □ [	ER/Outpatie	nt 3 DC	Othe	er: 4□Ni	ursing Ho	me 5 Res	idence	6 Dothe	r (Specif	y)	
Division of Vital	5 E		1	Manner of Death I ☑Natural 2 ☐ Accident	5 Pending investigation		ate of Injury Month, Day Y	(ear)	28b. Time o Injury	of 2	8c. Injury Work	yat k? Yes 2□	No	28d. Describe	how inju	ry occurre	od		
Divis	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:		3 Suicide 4 Homicide	6 Could not I	4   280. FI	lace of Injury uilding, etc.	- At ho (Specify	me, farm, si	reet, factory	, office			28f. Location ( City or To	Street ar wn, State	nd Numbe e)	r or Rura	I Route Num	ber,
	Hoepita 24 hours Funere etely fille	Medical (	29a.	Certifier (Check only one)	1 Certifying P 2 Medical Exa	miner: On th		xaminat											)
	To th within To th compl	Me	29b.	. Signature and	title of certifier			7	(02pt 12	2 ( ) 1/290	. License	e number						Day, Year)	
				1 Inc	eme O	Dn	real!	カ			140	006	117	7	(	8/3	-0	6	
0 St	1-10+1		30.1	Name and addre	ess of person who	completed o	cause of dea	th (Item	23a) (Type	, Print)	St	. />	tra,	ms					
		ate	31. 1	Date filed (Mont			2. Registrar	s Signat	ure eru	2			-11	,					
	Regist	rar			AUG 0 7	2006	Bacero		B. 6	our	,								

		1 - For AMEND#8 per FH State 8/2/2006 AACO	State of Maryla HFALTH DEPT CM	_	artment c		7	Re	eg. No.	6 2596
Physic		Decedent's Name (First, Middle, Last)     Paul Eugene Woods						Date of Deat Month July	Day	3. Time of Dear 06 1:55
/Medi Exami		4a. Facility Name (If not institution, give : 810 Janice Drive	street and number)			m, or Location	of Death		4c. County of An	
Funeral Director		5. Social Security Number 6. Sex 171-07-2661		rs. last birthday) 2 Yrs.	If Under 1 Y Months Da	ear If Unde ays Hours	Min.	Date of Birth (Month, Day, ept. 19	1913	9. Birthplace (State or For Country) Pennsylvani
Maryland -f show Ilou at	tor	10a. State 10b. County Maryland Anne Art		City, Town or Lo		Annapo.	lis		8	10d. Inside City Lin 1 X Yes 2 □
h with the 23a or 28a at be noti	Funeral Director	10e. Street and Number 810 Janice Drive			10f. Zip Co	<sup>de</sup> 214	03	1	0g. Citizen of Wh	
NOTE, MATYISTIC ALL IS-UUSO  ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If Item 27 is marked other then "naturel", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	by Funer	11. Marital Status  1 Never Married XX Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 194		Was Decedent If Yes, specify 1 ☐ Yes 2 🔀	Cuban, Mexica	an, Puerto Rica	Yes or No- in, etc.)		American Indian, White, etc. White
A I A I S-00-30 of within 72 hours aff giene. green "naturel", or the Medical Expire.	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual O kind of work d DO NOT use ro gn Serv	one during mo etired)			16b. Kind of Busi State De	partment
Maryialia ZIZIS d 2 should be filed within 7 th and Mental Hygiene Z7 is marked other then " traumatic event, the Mental	To Be C	17. Father's Name (First, Middle, Last) Chillison R. Woo	odward				ner's Name (Fi Zelda Y		Maiden Sumame, NG	
y Wich y and 2 sho sath and i n 27 is m	ľ	19a. Informant's Name/Relationship (Ty, Elizabeth Woodward	d/wife	810	Janice	Drive	Annapo		, city or Town, Si Maryland	
Dalltimore, Mcz permit. Pages 1 and 2.1 Department of Health at Important: if Item 27 is eny Injury or other trau		20a. Method of Disposition  XX Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	St. Mary	natory or other s Ceme	tery	8/2/20	06 <i>I</i>	Annapoli	ity or Town, State s, Maryland
DESTITION  Permit. Page Department of Important; if eny Injury or page.		21. Signature of Funeral Service License  23a. Part1. Enter the disease, or compli	Tille	ر ا	47 Duke	of Glo	ouceste	r St.	Annapo	eral Home lis, MD 2140
bol out, cate be executed /Medical Examiner physicien and the burial-transit	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	1/2 (1)	sequence of):	1346	se				Interval Between Onset and Death
the death certification of the attending ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 100 miles.	etal death 3	⊒Ectopic pregn ☐ Other (specif				23d. Date Monti	
quires thet the signed by	۾	Part II. Other significant conditions con	stributing to death but not	resulting in the u	nderlying caus	e given in Part	1.			ute to the cause of death
The law the has b	Completed				_			24a. Was ar autops perfore 1 Yes	ped2 de	ere autopsy findings availa or to completion of cause ath? Yes 2 \( \sum \text{No} \)
sician: The sectificate	Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatie	nt 3□ DOA	Othor	ce of Death (C	11	e) ence 6 □Other	(Canada)
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certificion completely filled in by the funeral director,	ation; To	27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o		Injury at Work? 1 Yes 2	28d		w injury occurred	
itel or Att rel Direct lled in by t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecity)				City or Town	i, State)	or Rural Route Number,
e Hosp 24 hou e Fune detely fi	Medical	29a. Certifier Check only 2 Medical Examin	ician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the vestigation, in	ne time, date a my opinion, de	and place, and eath occurred a	due to the ca t the time, da	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
To th Withir To th	Me	29b. Signature and title of certifier	~		29c. Li	cense number	66	29	9d. Date signed	(Monthy Day, Year)
		30. Name and address of person who co Dr. Eric C. Marca	lus 3169 Br	averton		Suite 1	101 Ed	gewate	r, Maryl	land 21037
St Regist	ate	31. Date filed (Month, Day, Year)  AUG 0 1 2	32. Registrar's Si		houle					

ORIGINAL

			1 - For State Registrar	State of	Marylar	-	artment of H			iene eg. No.	25961
			Decedent's Name (First, Middle, L.	ast)					2. Date of Dear	th	3. Time of Death
	Physici		James Harold	Way. Si	_				July	3/, 2006	22!45M
,	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death		4c. County of Deal	
			235 Blair Shor	re Road			Elkt	on		Cecil	
	Funeral		Social Security Number 6.	Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birl	hplace (State or Foreign
ь	Director		218-54-4386	1⊠M 2□F	55	Yrs.	Months Days	Hours Min.	Oct. 2	3,1950 EI	kton, MD
	p ,		Usual Residence of Decedent		10- 0	. T					
	aryla ahov	-	10a. State 10b. County		100.04	ity, Town or Lo					10d. Inside City Limits
	8a-f	Director	Maryland Cec:	.1			Elkton				1 ☐ Yes 2√2 No
	vith ti	ä	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath v	Funeral	235 Blair Shor				2192			USA	
	er de Itam	une	11. Marital Status	12. Was Deced	es?	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ XDivorced	1 Yes 2 If Yes, Give Year or Dat			1□Yes 2□No	Specify:		Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itama 23a or 28a-f ahow tha Madigal Examiner in that be notified at	edt	15. Decedent's 6		63.		dent's Usual Occupa	ation		16b. Kind of Business/	ite
15	in 72	Completed	(Specify only highest gi	ade completed)	4	(Give	kind of work done d DO NOT use retired,	luring most of work	ing	TOD. KING OF BUSINESS	industry
212	iene jene r the	ШО	Elementary/Secondary (0-12)	College (1-4	tor 5+)	Ren	oairman		ŀ	HVAC	
	i Hygid I Hygid other	0	17. Father's Name (First, Middle, Las	1)				18. Mother's Nam	e (First, Middle, f	Maiden Sumame)	
Maryland	ould be Mental Parked c	To B	Donald Way, Si					Sally	Lamber	t	
ary	shot and h	Γ.	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a			, City or Town, State, 2	Zip Code)
	and 2 salth a n 27 is		Judy Vannier -	- Niece		3255	5 Woodya	rd Road	, Harr	ington, D	E 19952
J.C	of He Item		20a. Method of Disposition	7		Place of Dispo	sition (Name of natory or other place	a)	Date	20c. Location - City or	Town, State
Ĕ	Pages nent of int: If it iny or o		1 ☐ Burial 2 ☐ Cremation 3 [ 4 [XDonation 5 ☐ Other (Speci		ate	natomy		*	/06	Hanover	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itama 23s or 28s-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature / Funeral Se Lice	nee CCO4	142		. Name and Addres				
Ω	8 9 E 8 8	. 7	Telety	I			eson Fu			Newark r <del>k, DE 1</del> 9	702
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cau	used the dear	th. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Par		Canc				The second secon	Onset and Death
	/Medical		resulting in death)	Due to (or	r as a consec		Zy.				6 years
п	Examiner		Sequentially list conditions	h							,
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	r as a consec	quence of):					
	nd trans	Examiner	Cause (Disease or injury that initiated events	c							
ő,	e exe	ŭ	resulting in death) Last	Due to (or	r as a consec	quence of):				W	
8760,	icate be executed physician and the burial-transit	dical	•	d							
9		Me	IF FEMALE:						· · · · · · · · · · · · · · · · · · ·		
Bo	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Feta	aldeath 3□	Ectopic pregnancy			23d. Date of deli Month	very Day Year
o.	the e	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9☐ Unknow	nt at time of o	ieath 5∟	Other (specify)				
Division of Vital Records, P.O. Box	The law requires that the death certifi ste has been signed by the ettending page 2 should be detached for use as	F.	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the ur	nderlying cause give	in in Part I	23a Did tob	pacco use contribute to	the cause of death?
ds,	sign d be	d by				3	, g 02200 g o		1 □ Ye	4.4	
ŏ	w requir been si should I	Completed								7	
ĕ	sician: The law certificete hes b irector, page 2 s	ш							24a. Was ar autops perforn	y prior to d	topsy findings available completion of cause of
<u>=</u>	icete			1					1□ Yes 2		2 No
₹	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Deat			
ō	Attending Physician: or death. actor: After this certific by the funeral director,	2	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatien 28b. Time of	1 3LI DOA	4   Nursing Ho		nce 6 Other (Spec	cify)
o	ding h. h. After funer	달	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	28c. Injury Work	? 'es 2□No	200. 0030100 110	w injury occurred	
S	or Attendate deat after deat Diractor: in by the	fica	3 Suicide 6 Could not t	99 Place o	f Injury - At h	ome, farm, stre	eet, factory, office		28f. Location (Str	reet and Number or Ru	ral Route Number
2	after Dira	Certification:	4 Homicide determined	building	, etc. (Speci	fy)	,,		City or Town	, State)	10010 11000,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	hysician: To the b	est of my kno	owledge, death	occurred at the time	e, date and place.	and due to the ca	use(s) and manner as	stated.
	a Ho a Fu	edicai	(Check only 2 Medical Exa	miner: On the bas and manne	is of examina	ation and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier	1			29c. License	number	29	9d. Date signed (Month	, Day, Year)
}			1 A Far	har,	70		1019	5314	1	ingust 1.	7001
			30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type, i	Print)	11	1/1	- 7~ 11	2006
_/	12		H Farkas,	10 5	lason	5 Hes	Nice E	Ikton,	MD.		
	Sta		31. Date filed (Month, Day, Year)	2006 N	istrar's Signa	ature 4	Print)  A/CR, E  Sparle				
	Registr	ar	nou A	2000	Kolver	15	The state of the s				

State of Maryland / Department of Health and Mental Hygiene [] [] [ For State Registrar Certificate of Death 1. Decedent's Name (First, Migdle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death Examiner Johns Hopkins Hospita Saltimore BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Min Hours 1**X**M 2□F Yrs PENNSYLVANIA Director 73 191-26-2262 7-3-1933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo DELAWARE SUSSEX DAGSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 #6 WINWARD WAY, THE GREENS U.S.A. Completed by Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 TELEPHONE COMPANY SUPERVISOR permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any njury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WALTER WIEST ဂ္ ELVIRA KLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENA K. WIEST/WIFE #6 WINWARD WAY, THE GREENS, DAGSBORO, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date I Burial 2 ☐ Cremation 3 Removal from State RESURRECTION CEMETERY 8-8-2006 4 Donatton 5 Otyler (Specify) HARRISBURG, PA. 21. Sign sture of Puneral 22. Name and Address of Facility MELSON FUNERAL SERVICES, I WEST AVE., OCEAN VIEW, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be d 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No death. within 24 hours after death To the Funerel Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hoepitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the h 29b. Signature and title of certifier 29c. License number Medical Lector 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Benjamin, The Johns Hopkins Hospital, 600 North Welle Street, Bultimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 0 3 2006

			1 - For State Registrar				t of He	ealth and M	lental Hygier	1 <b>e</b> 2006	25963
	<b>5</b> 1		1. Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death
	Physici /Medio		Beverly Eleanor W						الا كالىل	امرور م	0622 M
	Examin		4a. Facility Name (If not institution, give s			1		ocation of Death		4c. County of Death	
			memorial Hosp				510			Talbo7	
	Funeral Director		5. Social Security Number 6. Sex	7. Ago M 2√2 F	e (In yrs. last bir 69	Yrs. If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign untry)
			214-34-6131 Usual Residence of Decedent	Α	09	110.			Feb. 22,1	937 Mary	Land
1	yland		10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
10	ith the Marylar or 28a-f show	ctor	Maryland Dorchest	er	Secreta	ary					1 X Yes 2 □ No
D	ith th	Dire	10e. Street and Number			10f. Zij	Code		10g.	Citizen of What Cor	untry?
42	ath w	Funeral Director	107 Poplar Street				2166			USA	
0	items	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 Yes 2 X		13. Was Dece If Yes, spe	dent of His cify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
336	hours after death with the Maryland turei; or Items 23s or 28s-f show al Examinat the tutilied at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	•0	1 ☐ Yes	2🗓 No	Specify:		Specify: Wh	ite
5-0036	72 hours natural', dical Exp	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a.	Decedent's Usu	al Occupat	ion	16b.	Kind of Business/li	ndustry
~ 5	c * 3	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT u	se retired)	iring most of worki	ng		
Beverly Maryland 2121	should be filed within and Mental Hygiene. Is marked other then aumatic event, I a M	Con	12			Homemak				Own Home	2
and le	ould be fil Mental H arked otl atic even	Be	17. Father's Name (First, Middle, Last)				1		(First, Middle, Maid		
ઈ ₹	hould d Me mark matic	은	Earl Edward Cox, S		10h	Mailing Address	(Stroot or		orena Tay		in Condo)
€ E		ĺ	Lauren Wanex/Daugh	•					ry, Maryl		
k -	s 1 and 2 f Heelth Item 27 other tra		20a. Method of Disposition	,		Disposition (Natry, crematory or c				Location - City or T	
ع الح	Pages net of nt: If I		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation _5 ☐ Other (Specify)	emoval from State	1			se1 8/04/	2006 Se	cretary,	Marvland
ωσησης, Baltimore,	permit. Pages 1 and Depertment of Heelth Important: If Item 27 any injury or other tr once.		21. Signature of Frineral Service Licens	116	Na			-	, P. O. B		riar y rana
3 🗖	Dep Impe		general?	W. 4	eller	106 Ma	in St	reet, Ea	st New Ma	rket, MD	21631
		(	23a Parts. Enter the disease, or complications, or heart failure. List only on	ations that caused cause on each lin	the death. Do r	not enter the mod	e of dying,	such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition resulting in death)	inha	- Cere	brue	hor	northa	R		Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as	a consequence	of):			0		100
		-	Sequentially list conditions, b	Duy 8 10 as	a cons uence	of):					years
	uted	Examiner	Sequentially list conditions, by cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	te be executed ysician and e burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence	of):					
3760,	# % B	Icai	d								
39 X	eath certifica attending ph for use as th	Physician/Med	IF FEMALE:								
B <sub>0</sub>	ath cer attendir for use	lan/	23b. Was decedent pregnant in the past 12 menths?	3c. If yes, outcome of 1□Live birth	2 Fetal death					23d. Date of deliv Month	rery Day Year
P.O. Box	tt the de by the a	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	5 Other (sp	ecify)				
σ.	₹ 88	by Ph	Part II. Other significant conditions con	t <i>r</i> ibuting to death bu	it not resulting in	the underlying o	ause given	in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rds	quires n sign uld be	Q D	diabetes						1 Ves	2 □ No 3 □ Pro	bably 4 □Unknown
8	aw requisite pending 2 shoul	ompieted	elevoted 1	i sid					24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Division of Vital Records,	The lavele has page 2	mo							autopsy performed?	death?	
/ita	ician: certifice rector, p	BeC	25. Was case referred to medical examiner?					26. Place of Death		.0	
of o	Physi this c al dire	ို	1 ☐ Yes 2 ☑ Mo	ospital: 1 Inpatie				4   Nursing Hon	ne 5 ☐ Residence	6 ☐Other (Speci	fy)
E C	Jing F After funer	ion	27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. T 'Year) Ir	ime of 2 njury M	8c. Injury a Work?		28d. Describe how in	jury occurred	
İSİ	Attendi death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ırv - At home, fai			es 2 No	28f. Location (Street	and Number or Pur	al Poute Number
ē,	eler s efter i Dire d in b	Certification:	4  Homicide determined	building, etc	. (Specify)	, 6	, 511156		City or Town, Sta	ite)	ai riodio Namber,
	To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A comuletely filled in by the tr	edicai (	29a. Certifier 1 eritinin, Phys (Check only one) 2 Medical Examin	ician: To the basis of er: On the basis of and manner sta	examination and	death senuired	at the time in my opir	, date and place, a nion, death occurre	and due to the caused and at the time, date a	s) and manner as a nd place, and due t	stated. o the cause(s)
	with To 1	Σ	29b. Signature and title of certifier	11-	0	290	. License	number	29d. C	ate signed (Month,	Day, Year)
			1/1-6	· / Vm	æ		6 9	043	12	dry 31,	2006
			30. Name and address of person who con	mpleted cause of de	eath (Item 23a) (	Type, Print)	*	CV G	d.	111	1010
	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Altea?h	rete	St &	13 pm	000 2	60/
	Registr		AUG 0 2	2006	mas B	Acon					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07 DM 00 Edward 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Medica enter TIMOre -IMOr 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Months Hours 1 M 2 F Yrs. 47 Director 220 84 6435 MAY 17 1959 KOREA Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified a MD HOWARD ELLICOTT CITY 1√2 Yes 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10377 TUSCANY RD 21042 U.S.A death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian 1 Ves 2 □ No filed within 72 hours after Hygiene. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1□Yes 2□XNo If Yes, Give 9/4/80 Specify: Specify: ASIAN ģ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) 12 PROPRIETOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: if Item 27 Ie marked o ROBERT MIY JONG HEUI YT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10377 TUSCANY RD ELLICOTT CITY MD 21042 EUN YON YIMWIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ō Injury 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VA 8/2/06 OWINGS MILLS 22. Name and Address of Facility CHARLES HINDS FUNERAL SERV 21. Signature of Funeral Signature Licens 2 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EN CEPHALOPATHY HEPATIC **Physician** /Medical Due to (or as a consequence of): Examiner THE LIVER CIRRHOSIS OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page this certificate 2 D No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Funers 1@Centlying Physician: To the best of my knowledge destinoccured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 24 å within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREEN STREET, BALTIMORE, MD 10 BRIAN KARP N. 31. Date filed (Month, Day, Year) . Registrar's Signature-State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifi	icate of Death		Re	eg No 200	6 2596		
Physicia Medical Exami	41.0	Decedent's Name (First, Middle     Bernard	•				Date of Deal     Month	Day Year	3 Time of Death 1840 hrs		
- Carcar Exami	iiei	4a. Facility Name (if not institution	T.		Zmarthie	wn, or Location of	August 8, of Death	4c. County of Deatl			
		130 Kuethe Drive			Annapo			Anne Arundel			
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last b	oirthday) If Under Months			th(MM/DD/YYYY) 9. Bit Forei			
Director		065-34-4898	1 <b>XX</b> M 2 F	61	Yrs	Days Hours		20 1944 Cd	ountry) New York		
any	ŀ	Usual Residence of Decedent  10a. State 10b County		0c. City, Tov	vn or Location				10d. Inside City Limits		
<u> </u>	_	MD Anne	Arunde1	Ann	apolis				1 Yes 2 X No		
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip C	ode	11	0g Citizen of What Cou	**		
ith the Maryland 23a or 28a-f sho		130 Kuethe Dri	ve		21	403		USA			
th with	Funeral	11. Marital Status 1 Never Married 2 Ma	12. Was Decedent E Armed Forces?	ver in U.S.			gin? ( Specify Yes or No Puerto Rican, etc.)	- 14 Race - Amer White, etc.	ican Indian, Black,		
er dea			1X Yes 2	No		X No specify:	,				
ours afi etural	d by	15. Decedent's Education (Spec		nk leted) 16	a. Decedent's Usual Od	ccupation (Give I		Specify: Wh i			
6 172 bc	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+	-)	during most of working	ng life. DO NOT	use retired)	}			
5-0036 led within 72 Hygiene other than the Medical	dwo	17. Father's Name (First, Middle,	2		Artist			Painting			
21215-0036 ould be filed within 7 Mental Hygiene is marked other than is event, the Medical	BeC	Elwood Zmarthi	·				's Name (First, Middle, M Len Kerwin	Maiden Surname)			
2121 ould be fi d Mental I s marked ic event,	To E	19a. Informant's Name/Relations		1	19b. Mailing Address	(Street and Num	ber or Rural Route Num	nber, City or Town, State	e, Zip Code)		
NOTE, MD 21215-0036  gges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene  t: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once		Eleanor Melogr	ana (Daughter		12 Chelses	a Court,	Annapolis				
5 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	П	20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from State		e of Disposition (Name natory or other place)	of cemetery,	Date	20c. Location - City or	Town, State		
Pag Pag ment tant:		4 Donation 5 Other Sp	ecify:		o Crematory	7	8-11-2006	Baltimore	, MD		
Balt permit Depart Impor		21. Signature of Funeral			Hardest	ty Funer	al Home, P	. A .			
Physician	Н	23a. Part I Enter the disease, or	complications that caused th	ne death. Do	not enter the mode of	dying, such as c	enue . Annapo ardiac or respiratory arro	olis, MD 21 est, shock, or heart			
/Medical Examiner	1	failure. List only one cause Immediate Cause (Final disease		e athero	osclerotic ca	rdiovascu	lar disease		Between Onset and Death		
		or condition resulting in death)	Due to (or as a conseq	uence of):							
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
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evecuted an and al - transit		events resulting in death) Last	d	1407100 01/1							
760, Teate be executed physician and the burial - transit	Medical/	X UNPENDED	☐ AMENDED ite	em#23a.F	PII,27,per ME	. G858.*/2	25/06 TT				
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be death ector. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri.	n/Me	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome	of pregnance	cy 2 Fetal death	_		23d. Date of deliver			
Box 687 ne death certific the attending p	Physiciar	past 12 months?	4 Pregnant at ti		5 Other (Specific		pregnancy	Worth	Jay Year		
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Division of Vital Records, pital or Attending Physician: The law requirement after death neral Director: After this certificate has been sifilled in by the funeral director, page 2 should the	Certification:	deter	d not be 28e. Place of Injustmined (Specify)	ry - At home	, farm, street, factory, o	ffice building, et	c. 28f. Location (S or Town, S	Street and Number or Ru tate)	iral Route Number, City		
Hospit 14 hour Funer ely fill		4 Homicide  29a Certifier 1 Certifying Ph	nysician: To the best of my	knowledge, o	death occurred at the ti	me date and pla	ace and due to the caus	e(s) and manner as star	ted		
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		miner:On the basis of exami								
F % F 8	ž	29b Signature and title of certifie				icense number		29d. Date signed (Mo	nth, Day, Year)		
		Maria Dia	sell MS	)—		D.C.M.E.		August 9, 2006			
		30. Name and address of person Melissa Brassell, MD	who completed cause of dea Assistant Medical E		•	et, Baltimore	e, MD 21201				
	ate		32 Registrar's		1 4	,					
Regis	trar	AUG 11	2006	15	Broke						

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 **Physician** 10:10 AM Η. August /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore tranklin 10spital Osedale square 8. Date of Birth (Month, Day Ye March 15, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** Hours Min. Months Days 1□M 2√F 75 Pennsylvania 217-48-9573 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8416 Rocky Mt. Road 21237 USA filed within 72 hours after death Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🕱 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Manicurist Olivers Hair Design permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elias D. Clio **Anastasiadou** Harjandreou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) William E. August / Husband 8416 Rocky Mt. Road Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

1 Donation 5 Mother (Specify) Entombment Greek Orthodox Mauso. 8/17/06 Woodlawn, Maryland 21. Signature of Sunoral Service Literase 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 a æ 23a. Part1. Enter the Iseas or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manher of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES DOO August, 14, 2006 OI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Space Drive Balto, Md 21237 9000 son Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Askew Bluist AROLYD DORIS **Physician** 2006 12 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Medical Cint Examiner HARLOND CHESOPORE BELAIR If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

n. Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, al Security Number Days **Funeral** Hours 1 M 2 M 56 55 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County itsm 27 is marked other than "natural", or itsms 23s or 28s-4 show other traumatic svent, the Medical Examinar trust the notified at 1 Yes 2 No Edgewood Directo MANGLARD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21040 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify:~ Maryland 21215-0036 δ Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) VERIZON College (1-4or 5+) Elementary/Secondary (0-12) (BINDAM) permit. Peges 1 and 2 should be filed within Depertment of Heelth and Mental Hygiene. Important: If Itam 27 is marked other then any Injury or other traumatic avent, Itam ponce. ENGINGE, C IECHNICIAN) WEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 40
1309 Clover Valley Way Charles Edge No. 1864 19a. Informant's Name/Relationship (Type, Print) Clover Valley Way ERNEST BLUNT, HUSPANIC Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Creensearch Ceretas 22. Name and Address of Facility C HA THAT - HAVES KNOWN FREE 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC RAPPER CANCEL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of

Records, of Vital Division Blunt,

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Certification:

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

W: 2215

Below nos

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Distor - 12, 7006

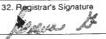
Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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 and address of paragon up	he completed cause of death (Item 23a) (Type Pri	n

N. MO-Php. 1 D45 12 2 615 D =

31. Date filed (Month, Day, Year) State Registrar

25a. Certifier





		•	1 - For State Registrar	State of Ma	aryland	-	artment of I	lealth and N	Mental Hy	/giene	2000	25968
- 1	Physici	an	Decedent's Name (First, Middle, La	•					2. Date of De	eath Da	y Year	3. Time of Death
	/Medic	al		eus M. B	roda		4 0 T		8	14	06	5:02PM
	Examin	er	4a. Facility Name (If not institution, give		H051	o tal	46. Cry, Town, 6	or Location of Death	0	40	County of Death	timore
	Funeral		5. Social Security Number 6.	Sex 7. Ag	<del></del>	ast birthday)	If Under 1 Year		8. Date of Bi (Month, D	rth	9. Births	place (State or Foreign
	Director		213-30-2321	<b>3X</b> ]M 2∏F	65	Yrs.	Months Days	Hours Min.	Sept.	16,	1940 MA	ryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Maryland -f ehow	টু	MD Balt	imore	(	Chase						1 ☐ Yes 2 No
	death with the Marylar me 23e or 28a-f ehow rmat be notified	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cour	ntry?
	23 c	a D	13113 East Gr	eenbank 1	Road		212	220		US	A	
w.		nue	11. Marital Status	12. Was Decedent Armed Forces?		6. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp ean, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Americ Black, White,	
3,8	a o	by F	1 ☐ Never Married	1 ☐ Yes 2 🐼 I If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ☐ No	Specify:			Specify:Whi	
418	72 hours	ted	15. Decedent's E	ducation			dent's Usual Occup			16b. F	(ind of Business/In	
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212	filed wil Hygien ther th	5		2yrs		Cysc			+		inance	
	ild be filed fental Hygirked other ilc event, I	Be	17. Father's Name (First, Middle, Last					18. Mother's Nam				
Maryland	should be and Mental marked umatic ev	은	Anthony John 19a. Informant's Name/Relationship			10b Mailie	an Address (Street	Angela  tand Number or Run				Codel
Za Za	alth a		Dolores L. B		fe			Greenba			or rown, state, zip	(000)
- J.	of Hee		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other pla		Date	1	ocation - City or To	own, State
OE OE	Pag nent ant: if		1 🄀 Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		Ho.	lly H	ill Cem	nétery8/	17/06	Ba.	ltimore	MD
Salt	permit. Pa Depertmer Importent: eny injury		21. Signature of Funeral Service Lice	nsee	0	/ 22	. Name and Addre	ess of Facility 3 C	0 Mac	e A7	ve. Balt	O MD
-	<u>vo</u> = • α		K. Juri	John	M	41	Connell	y Funera	1 Home	e of		21221
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	one cause on each li	the death.	not ent	er the mode of dy	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	IVE	> H	emott	Y515				
	Examiner			Pulm	O Cal	CV F	+rton	V RIPP	ding			
	P (1/=	ner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):		1 0 10 -	-			
	ate be executed hysicien and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· non s	ma	1 (	e11 11	lng ca	-ncer	in	Right uppe	r 10be
8760,	icien a	Icai E	1	Due to (or as	a consequ	ence ot):						
687	0 0			_ d								
Вох	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			De				23d. Date of delive	ery
	deatl	sicia	in the past 12 months? 1 Yes 2 No	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pregnanc Other (specify) _	y			Month	Day Year
P.O.	at the ded by the destached	Phy	9 Unknown						1			
	ires that signed t	þ	Part II. Other significant conditions	contributing to death b	ut not resul	lting in the u	nderlying cause gr	ven in Part I.	1		use contribute to the	ne cause of death?
Š	w requir been si should I	etec							9-1-1-1			
Rec	The lav	Ē							24a. Was auto		24b. Were auto prior to con death?	psy findings available mpletion of cause of
Division of Vital Records,		60	25. Was case referred to medical					26. Place of Deat	1 Yes	2 N		2 No
Ξ		To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1 Inpatie	ent 2 🗆 E	R/Outpatier	t 3 DOA Ott	hor			6 ☐Other (Specifi	ν)
0	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Ont of Inju (Month, Da	ry y Year)	28b. Time o	28c. Inju Wo		28d. Describe			
Si Si	Attending r death. ector: After by the funer	Certification:	2 Accident investigation	n			M 1	Yes 2□No				
Σ	or At ofter d Direct in by	Ħ.	4 Homicide determined	28e. Place of Injuding, et	ury - At hor c. <i>(Specify)</i>	ne, farm, str	eet, factory, office		28f. Location ( City or To	(Street a. wn, Stat	nd Number or Rura e)	l Route Number,
	lospital hours e unerel [	0	29a, Certifier 117 Certifying P	hysician: To the best	of my know	dedge deat	Occurred at the t	me date and place	and due to the	021100/0	) and manner on a	tatad
	T 4 F 5	edicai	(Check only 2 Medical Exa	and manner sta	examinati	on andor in	vestigation, in my	opinion, death occur	red at the time.	, date an	d place, and due to	the cause(s)
	To the within 2 To the comple	ž	29b. Signature and fille of certifier				29c. Licens	se number		29d. Da	ite signed (Month,	Day, Year)
			May				1Ke	5000	00	08	115/0	6.
	10		30. Name and address of person	completed cause of d	leath (ttem	23а) (Туре,	Print)				-	
			VI-Viana V	0/905	46	00 F	100151	in 591	Mare	20	Cive BOY	timeremoal
3	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registra	ars Signati	ure 9	1 4.					
DH	MH 17 Rev 1/2		AUG 17	2006	ر مانتون	15 p	Jew )					
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			rieasi	e Type or Print in Blac			-	_	
			1 _ State	State of Maryland / I			lental Hygi	ene	25969
			- State Registrar		Certificate of	of Death	Re	g. No U U U	2000
	Dhusisi		Decedent's Name (First, Middle, I	Last)			Date of Death     Month	Day Year	3. Time of Death
	Physici /Medio		Jeanette Ja	ohnson barnes	<u> </u>		08	11 2006	9:30 PM
	Examir		4a. Facility Name (If not institution, g	nive street and number)	4b. City, Tow	m, or Location of Death		4c. County of Deatl	1
			Stella Maris	Hospice	Tim	onium		Baltimo	RC
	Funeral		Social Security Number     6.	Sex 7. Age (In yrs. last bit	rthday) If Under 1 Your Months Da	ear If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign
	Director		217-20-0512	1□M 2 <b>B</b> F 83	Yrs.		01/27/	1923	MD
	pu 🛦		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
	anyla shov	_	Toa. State						1 ☑Yes 2 ☐ No
	8 -1 M	octo	MD NA	Balti	more				
	or 2	Dire	10e. Street and Number		10f. Zip Coo		10	g. Citizen of What Co	untry?
	within 72 hours after deeth with the Maryland she. than "natural", or itama 23s or 28e-f show he Wedical Examinar must be notified at	Funeral Director	3722 Cheshi	olm Koad	313			USA	
	tam tam	nne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent If Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give	1 ☐ Yes 2 🖪	No Specify:		Specify:	
21215-0036	urai'	d D		Year or Dates:				BIG	ick
5	"nat	Completed	15. Decedent's (Specify only highest of		<ul> <li>Decedent's Usual Or (Give kind of work do life, DO NOT use re</li> </ul>	one during most of work	ing	6b. Kind of Business/l	ndustry
12	withii iene. than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		1	. 1	2/ /-20	)
C	Hygie ther	ပိ	17. Father's Name (First, Middle, La	2 YRS Ae	<u>Iministrat</u>		e (First, Middle, M.	egal A	d
ä	Mental Mental Marked or	Be	V. V.	•				alden Sumame)	
Ë	should nd Men marke imatic	2	Albert Hawk		Adallia - Add /Gr	reet and Number or Run	ackson	C' T	?- O- d-1
Maryland	C 4 2 2		19a. Informant's Name/Relationship		o. Mailing Address (St	reet and Number of Hur			ip Code)
	permit. Pages 1 and 3 Depertment of Heelth Important: If item 27 any injury or other tr. onca.		Albert Barnes	JR (SON) 98	f Disposition (Name o	old Rd, to	Date 2		21133
9	t of t		1 ⊠ Burial 2 ☐ Cremation 3	comete	ry, crematory or other	place)		0c. Location - City or	
Baltimore,	men tant:		4 □ Donation 5 □ Other (Spec	Unian	d Kidge	108/1	1/2006 F	ikesville,	MD
ä	permit. Pa Depertmen Importent: any injury once.		21. Signature of Funeral Service Lic	censee	22. Name and Ad	ddress of Facility	meral Sv	C	
ш	40 E # 0		Yaugho C	. ariene	5151 Bal	ddross of Facility Greene Fi	, Baltima	Re MD	21339
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused the death. Do	not enter the mode of	dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a_PANCREATIC CAN	ICED				Onset and Death
/	/Medical		resulting in death)	Due to (or as a consequence		.,			
	Examiner								
		Je.	Sequentially list conditions,	Due to (or as a consequence	of):				
18	death certificate be executed e attending physicien and of for use as the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c					
٥,	exer en ar rial-ti		resulting in death) Last	Due to (or as a consequence	of):				
760,	ysicir e bu	cai		d					
68	g phy as th	ed				_			
Вох	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	.05			23d. Date of deli	very
m	death d for	icia	in the past 12 months? 1 □ Yes 2 📉 No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregna 5 ☐ Other (specif)			Month	Day Year
P.O.	by the	hys	9 Unknown	9∐ Unknown					
	requires that the de een signed by the a hould be detached t	by Physician/Med	Part II. Other significant conditions	contributing to death but not resulting i	n the underlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	purre n sig	d b					1 ☐ Yes	2 □ No 3 □ Pro	bably 4X Unknown
8		Completed					24a. Was an	24h Were au	opsy findings avaitable
Re	: The law cete has b page 2 si	Ē		<del></del>			autopsy perform	prior to d	omptetion of cause of
a	icien: Th certificete rector, pag		OC Management to madical				1 □ Yes 2		2□ No
of Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	h (Check only one		HOADTAD
o	Phy this raldi	2	1 ☐ Yes 2 📆 No 27. Manner of Death	1 Inpatient 2 ER/O	utpatient 3 DOA DOA Time of 28c.	4 LI Nursing Ho	me 5 Residen	ce 6 COther (Spec	(fy) HOSPICE
5	Jing After fune	io io	1 Natural 5 ☐ Pending	(Month, Day Year)		Injury at Work? 1 ☐ Yes 2 ☐ No	200. 0030100 1104	vinjury occurred	
Division	Attending or death.	Certification;	2 Accident investigat 3 Suicide 6 Could not	the 290 Place of Injury - At home for			28f Legation /Stre	eet and Number or Ru	ral Pouta Number
⋛	or A after Direct	E I	4 Homicide determine	building, etc. (Specify)	arm, street, lactory, on	109	City or Town.		ar noute Number,
]	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ŭ	29a. Certifier TV Certifying	Physician To the head of a street of	a doub	and discount of the	and during the st		
	Hos 24 ho Fun Fun	edical		Physicien: To the best of my knowledge aminer: On the basis of examination ar	e, death occurred at th nd/or investigation, in r	ne time, date and place, my opinion, death occuri	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c 1 is	cense number	900	d. Date signed (Month	Day Year
	₹ <u>₹ 8</u> 8	_	255. Signature and title of centries		7		290	1 1	
7			/ / /			43725		8/14/00	7
	2		30. Name and address of person wh	no completed cause of death (Item 23a)	(Type, Print)				
	J		DR. TARIQ MAHM		VALLEY RD.	. TIMONIUM	, MD 2109	93	
	Sta		31. Date filed (Month, Day, Year) AUG 1 7	2006 32. Registrar's Signature	Coarte				
	Regist	eli.	AUG I	go respond the	Labora Alex				

DHMH 17 Rev 1/2001

AUGUST 11, 2006 9:30 p.m.

JEANETTE BARNES

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		4	For State Of Mary Registrar		tificate of		Re	2000 eg. No.	25970
	Physicia	200	1. Decedent's Name (First, Middle, Last)				Date of Deat Month		3. Time of Death
	/Medic	al -	Beatrice Elizabeth Bindeman				August		2:00 A M
4	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Deat	
			5520 Carville Avenue  5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	A If Under 1 Year	rbutus If Under 24 Hrs.	9 Date of Birth	Balti	
	Funeral Director			82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sep. 18,	Year) Co 1923 Ma	nplace (State or Foreign untry) ryland
	land II	-		c. City, Town or Lo	cation				10d. Inside City Limits
	Marylan f show	ō	MD Baltimore		Arbu	tus			1 ☐ Yes 🏖 No
	with the Maryland a or 28a-f show	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	untry?
	3a o	<u>=</u>	5520 Carville Avenue			21227		United St	ates
036	72 hours after death with the Maryla natural, or Items 23a or 28a-1 shov iteal Examinan must be incliffed at	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Deced (Give life. L		ation during most of world)	king	16b. Kind of Business/	Industry
21	filed withi Hygiene. other than	Con	10		Clerk			Retail	
pu	S should be filed within and Mental Hygiene. is marked other than aumatic event, I'll M	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, M		
yla	ould be Mental	ဥ	Ernest Albert Arnold, Sr.					Prevost	
Jac	s 1 and 2 should Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)					; City or Town, State, Z O 1 2 2 7	(ip Code)
	s 1 and 2 of Health item 27 other tr	-	Anne Breitenother - Daughter  20a Method of Disposition	Ob. Place of Dispo	sition (Name of	renue, Rei		20c. Location - City or	Town. State
Baltimore,	permit. Pages Depertment of Important: If its eny injury or or once.		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Loudon Pa Cemete	natory or other place TK Ery	8-16-	-2006	Baltimore,	MD
Ball	Depermit Deperment Importent ony in		21. Signature of Funeral Service Literase					neral Home, rbutus, MD	
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	hysician   Medical personner   Medical   Examiner   Medical as the prival transit   The prival transit   Medical personner   M	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a condition of the con	thoma maquenes off:	tails	e iluri			
P.O. Box 68	The law requires thet the death certific thas been signed by the attending proage 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnance Other (specify)	y		23d. Date of del Month	ivery Day Year
	signed by	۵	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.		pacco use contribute to	the cause of death?
Division of Vital Records,		Completed					24a. Was a autops perforr	ry prior to death?	stopsy findings available completion of cause of
ta		Be C	25. Was case referred to medical examiner?				th Check only on		
<b>†</b>	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier		4 🗆 Nursing H	ome 5 Reside	ence 6 □Other (Spe	cify)
ion o	After After funer	ation:	27. Manner of Death  1 ■ Natural 5 □ Pending 2 □ Accident investigation	ear) 28b. Time o	Wo	ryat rk? ]Yes 2 □No	28d. Describe ho	ow injury occurred	
Divis	2 th 2 in	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	- At home, farm, str Specify)	reet, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	ledicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of management of examiner: On the basis of examiner and manner stated	amination and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed (Monta	h, Day, Year)
	/		m Mm.		105	1811		August 14,	2006
	5		30. Name and oldress of person who completed cause of death	Balting		0 2122	- 8	August 14, Thomas	Chiory
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 (2006 32. Registrar's	Signature	de			100	

			For State Registrar	S	tate of	Marylan	-			ealth a D <i>eath</i>	ınd M	lental Hy	gien Reg. No	21111	6	25971
	Dhysiai	an l	1. Decedent's Name (First, Middle	Last)								2. Date of De Month	ath Da	v Y	ear	3. Time of Death
	Physici /Medic		Martha H.	_Ben	eze							August	12,	2006		5:40P M
	Examin	er	4a. Facility Name (If not institution,	_		oer)				Location o	f Death			County of		
			1702 Woodholme			. "			isbu:		34 Hrs			icomic		
	Funeral		5. Social Security Number 255-20-5636	6. Sex 1 ☐ M	2[X] F	Age (In yrs. ) 84	last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt 3-21-1	h Year	9.	Cour	lace (State or Foreign oftry)  GA
	Director	}	Usual Residence of Decedent									3 21 1.				- OA
1	Now H		10a. State 10b. County			10c. City	y, Town or Lo	cation							1	0d. Inside City Limits
1	War Tal	ţo	MD Wicom	ico		S	alisbu	ry								1 ☐ Yes 2X No
	2,28	i e	10e. Street and Number			-		10f. Zip	Code				10g. C	tizen of Wha	al Cour	itry?
1	23a (	a	1702 Woodholme	Cour	ct				218	04						USA
1		by Funeral Director	11. Marital Status	12.	Was Deced Armed Forc	ent Ever in U. es?	.S. 13.	Vas Dece	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Black, 1		
ဓ္	or it	Y.	1 Never Married 2 Marri	ed be	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes		Specify:				Specify:		hite
9	ure!	g p	3 AWidowed 4 □ Divorced		Year or Dat	9 <i>s</i> :										
က်	winn /z nours atter deem win fre maryland ene. Ithan 'naturel', or iteme 23a or 28a-f show the Madical Examiner must be notified at	Completed	15. Decedent (Specify only highes	grade co	mpleted)		16a. Deced (Give	kind of wo	rk done a	luring most	of works	ng	166. 1	(ind of Busin	iess/ind	dustry
77	the the	E	Elementary/Secondary (0-12) 1 2		College (1-4	lor 5+)			etar				Εdυ	catio	n	
ם פ	Hyg other	Be C	17. Father's Name (First, Middle, I	ast)			1			18. Mothe	r's Name	First, Middle,	Maide	Sumame)		
a	fenta fenta rked rked	To B	Joseph Foster	Jack	tson					Ex	ie M	laude Lo	ogue	:		
a Z	and A bus		19a. Informant's Name/Relationsh	ір (Туре,	Print)		19b. Mailir	g Address	(Street a	and Numbe	r or Rura	A Route Numbe	er, City	or Town, Sta	te, Zip	Code)
Σ ,	alth a		Mrs. Patricia K	ern /	daug	hter	1702	Wood	lho1m	e Cou	rt,	Salisbu	ıry,	MD 2	1804	4
ore.	of He of He roth		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation	2 □ Dom	aval from St		lace of Dispo	sition (Nai	me of other place	9)		Date		ocation - Cit	•	
Ě	Pag ment ent: i	0	4 Donation 5 Other (Sc		oval iloin Şi	Gle	n Have	n Cen	neter	У	8/16	5/2006	Gle	n Bur	nie	MD 21061
Baltimore, Maryland 21215-0036	permit, Pages 1 end 2 should be liet within 72 hours after deem with the marylan Deperment of Health and Mental Hygiene. Dependent if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be multiled at once.		21. Signature of Keral Service I	ice is	In	M0136						ngleton en Burn:				e P.A.
P	hvsician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complicationly one of	ons that cau	h line.	h. Do not ent	er the mod	te of dying	g, such as	cardiac o	or respiratory ai	rest,			Approximate Interval Between Onset and Death
	cate be only sicie the builties of the builtie	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c. d.	F	as onsequences	vence of):	~ ~								
O. Box 6	es that the deeth certific igned by the ettending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c.	1 Live birt	ome of pregna h 2 ∐ Fetal nIaI time of do n	I death 3	Ectopic p						23d. Date o Month		ery Day Year
rds, P	w requires that been signed by should be deta	<u>م</u>	Part II. Other significant conditio		outing to dea		ulting in the u	nderlying o	ause give	en in Part I.		23e. Did to				ne cause of death?
	ine law re ste has bec page 2 sho	Completed		0								24a. Was autop perfo		prio dea	r to cor th?	psy findings available upletion of cause of
E E	ortifica ctor.	Bec	25. Was case referred to cal examiner?							26. Place	of Death	Check only				
<u> </u>	nysic his ce I dire	흔	1 ☐ Yes 2 ☐ No	Hos	oital: 1 □ l <i>n</i> p	oatient 2	ER/Outpatier	t 3 D	Othe Othe	9F. 4 □ Nu	rsing Ho	me 5 lesio	dence	6 Other (	Specify	<i>y</i> )
ouo	Auending Physician: r death. ector: After this certifice by the funeral director, I		27. Mann of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investig		28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	M	28c. Injury Work	al ? Yes 2 □1		28d. Describe I	ow inju	iry occurred		
DIVISI	of or Attend efter death Director: / d in by the f	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	ot be	28e. Place o building	f Injury - Al ho j, etc. (Specify	ome, larm, str y)					28f. Location (S City or Tox			or Rura	l Route Number,
	spire nours nora nora / fille	edical C	29a. Certifier (Check only one)  1 Certifyin 2 Medical I	g Physici Examiner	On the bas	is of examina	tion and/or in	vestigation	i, in my op	pinion, deat	th occurr	and due to the ed at the time,	date ar	d place, and	due to	the cause(s)
4	o the he within 24 to the Fu	₹ E	29b. Signature and title of certifier					29	c. License	number	-		29d. Da	ite signed (A	Aonth.	Day, Year)
) '	0		) y	7	m				10	1005	D41	4		8	1/14	1/06
	de de		30. The and address of erson	vho comp	leted cause	of death (Item	n 23a) (Type,	Print)		3			_	-	. '	no 21801
	v		31. Date filed (Month, Day, Year)	JA	RAN	Mistrar's Sinner	1205	Ver	-her	mb	20	uti 101		chsbin	7 1	no 71801
	Sta Registi		AUG 1 7	2006	120	لكر صوبي	A STATE OF THE PARTY OF THE PAR									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Dorothy 2000 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Bel Air Harford Health and Rehabilitation Conter if Under 24 Hrs 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Days Hours Months 1 □ M 200 F 89 MARYLAND 212-62-9294 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes YNO BALTIMORE ROSEDALE MD 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? U.S.A. 34TH STREET 7910 21237 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **ANDREWS** FRANK CATHERINE (GETZ) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE M. RUTH/DAUGHTER 1501 CRESTVIEW ROAD JOPPA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 8-19-06 BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, 21237 MD23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place ath Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 13 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

**Physician** /Medical Bysenham P.O. Physician: To the Hospital within 24 hours a To the Funeral C

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**Physician** 

/Medical

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Director

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filed within 72 hours after

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Pages 1 ment of H ant: If Ite ury or ot

Department o Important: If any injury or once.

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Begistrar's Signature

1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Maryland / Do	epartmen Dertificat			and Me	ental Hy	giene Reg. No.	006	25973
ı	Physici		<ol> <li>Decedent's Name (First, Middle, L Mary Margaret Cain</li> </ol>	ast)						2. Date of Do Month Aug 1(	Day 2006	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, gi					Location o	of Death		4c. Cou	nty of Death	
			Baltimore-Washington 5. Social Security Number 6.		nter Age (In yrs. last birth		n Bur	If Under:	24 Hrs.	8. Date of Bi		Arunde	
	Funeral Director			1 □ M 2 🕽 🗲	82 Y	Months	Days	Hours	Min.	(Month, D	ay, Year)	Col	nplace (State or Foreign untry) MD
			Usual Residence of Decedent							.p. 11 20	, 1321		
	rylan		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Ba-1s	ct	MD Anne Arun	del	Millers	ville							1 ☐ Yes 2, No
	er 2	Dire	10e. Street and Number			10f. Zip					10g. Citizen	of What Cou	intry?
	ath w	ra	8049 Veterans Hwy, L				108					USA	
21215-0036	s 1 and 2 should be filed within 72 hours efter deeth with the Maryland of Health and Membal Hygiene. If Health and Membal Hygiene a few strains 23a or 28a-f show other traumatic event, tra Medical Examinar must be notified a	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3√√2 Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tes 2 If Yes, Give Year or Date	es? No	13. Was Deced If Yes, spec 1 ☐ Yes			gin? (Spec n, Puerto R	ify Yes or Nican, etc.)		Race - Amer Black, White cify: Wh:	
5-0	72 h	Completed	15. Decedent's I	Education rade completed)	1 6	ecedent's Usua Give kind of wo	rk done o	lurina most	t of workin	a	16b. Kind of	f Business/li	ndustry
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	ntal H ed ot	Be	17. Father's Name (First, Middle, Las	it)							, Maiden Surr	name)	
N N	d Men narke natic	은	Lawrence Ambrose	(Taran Orian)	401		10		Gothe				
Mai	12 sh hand 7 Is m rraum		19a. Informant's Name/Relationship	(Type, Print)	19b. I	Mailing Address	(Street a	and Numbe	er or Rural	Route Numb	er, City or To	wn, State, Zi	p Code)
a)	am 2	1	Sandra M. Watts  20a. Method of Disposition	Daughter	20b. Place of D	04 Montgo	mery	Dr., G	len Bu				
Baltimore	ges if ite or of	1	x Surial 2 ☐ Cremation 3	Removal from Sta	ate cemetery,	crematory or o	ther place				20c. Locatio	•	own, State
Ħ	t. Pa ntmen ntant:		*4 □ Donation 5 □ Other (Spec		Cheltenh			1	g 14,	2006	Cheltenh	nam, MD	
Bal	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra	4	21. Signatur Tyneral Service Lice K. *Gregory Arnk	4	01148	22. Name an Fink Fun 426 Crai	eral	Home,	P.A.	nie. MD	21061		
F	Physician		23a. Part 1 Enter the disease or co shock or heart failure. List on Immediate Gause (Final disease or condition resulting in death)	nplications that cau y one cause on eac a		t enter the mod	e of dying	g, such as	cardiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions,	Due to (or	as a consequence of								
	al iii	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events		as a consequence of	):							
8760,	tale be executed by sician and the burial-transit	dical Exa	resulting in death) Last	c. Due to (or	as a consequence of	):							
89	tifica ng ph as th	ledi		_									
О. Вох	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown		n 2 □ Fetal death t at time of death	3 □Ectopic pr 5 □ Other (sp						Date of deliv Month	very Day Year
rds, P.	w requires that been signed t should be deta	ed by P	Part II. Other significant conditions	contributing to deat	h but not resulting in t	he underlying c	ause give	en in Part I.			tobacco use co Yes 2 🖼		the cause of death?
Records,	ician: The law requ certificate has been rector, page 2 should	Completed								24a. Was auto perfe		prior to co death?	opsy findings available ompletion of cause of
Vital	ian: rtifica stor. 1	BeC	25. Was case referred to medical					26. Place	of Death	(Check only		12.00	20110
<b>)</b>	Physician: this certificinal director,	10	examiner? 1 Tes 2 PNo	Hospital: 1 Inp	atient 2 ER/Outp	atient 3 DC	Othe	9r. 4 □ Nu	rsing Hom	e 5 ☐ Res	idence 6 🗆 0	Other (Speci	fy)
			27. Manner of Death	28a. Date of (Month.		ne of 2	8c. Injury Work	at	28	d. Describe	how injury occ	curred	
Ö.	ttendir death. ctor: Af / the fu	atic	1 Natural 5 ☐ Pending investigati	on	,	M		res 2□1	No				
Division	or Attendated after death Director:	Certification;	3 Suicide 6 Could not determine	d 200. Place of	Injury - At home, fam , etc. <i>(Specify)</i>	n, street, factory	, office		28		Street and Nu wn, State)	m <i>ber</i> or Rur	al Route Number,
	pital ours a eral l		29a. Certifier Certifying F	husialas. Ta the b	and of any language days	d a a the a second of							
:	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	edicai	(Check only 2 Medical Exp	aminer: On the bas and manner	est of my knowledge, is of examination and/ r stated.	or investigation	at the tim , in my op	oinion, deat	d place, ar th occurred	d due to the d at the time,	date and place	manner as se, and due t	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			290	. License	number	21.		29d. Date sig	ned (Month,	Day, Year)
•	1		144	mm 7			DB	000	9		2/11	4 60	ko
	7		30. Name and address of person	o completed cause	of death (Item 23a) (T	ype, Print)	~(~	(	le	che o	no 2	161	9
	Sta Registi		31. Date filed (Month, Day, War) AUG 1 7 2	006	istrar's Signature	berli							-

DHMH 17 Rev 1/2001

ORIGINAL

Denise Constance Coates

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			Registrar		Certifica	ate of	Death			R	leg No	JUD	6031
Physedical Exa		er		Constance	Coate	es –				Date of Dea Month August 12	Day Yea		Time of Death 1340 hrs
*			4a. Facility Name (if not institution, g Saint Mary's Hospital	ive street and number)		41	o. City, Town, o Leonardtov		of Death		4c. County of St. Mary		
Fune	ral		Social Security Number 6.	Sex 7. Age	(In yrs. last birt	hday)	If Under 1 Ye		er 24Hrs.	8. Date of Bi	rth(MM/DD/YYYY		ace (State or
Direct	or	Į	332-48-3700	M 2X F	53	Yrs.	Months Da	ys Hours	Min.	OCT 3	1, 1952	Foreign Countr	y) <b>Ill</b> inois
any		F	Usual Residence of Decedent  10a State 10b. County		Oc. City, Town	or Locatio	n .					I 10	d. Inside City Limits
*	i,	_	Maryland Saint	Mary's	•		idge						Yes 2 X No
farylar 28a-f s	at on	Director	10e. Street and Number	11117 5		Ī	10f Zip Code			1	10g. Citizen of Wh		2.1
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 23s marked other than "natural", or items 23a or 28a-f she	e notified at once,	إة	16244 Millers Wh	arf Road			2	20680			U	ISA	
ath wit	st be r	Funeral	11. Marital Status  1 Never Married 2 X Marrie	12. Was Decedent E Armed Forces?			Decedent of H s, specify Cuba				14. Race White		Indian, Black,
fter de: <b>17. or i</b>	er m	핈		1 Yes 2 A	No	1	Yes 2 X N	specify:			Specify:	Wh	ite
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5-00; led with tygiene	he Me	튅	17. Father's Name (First, Middle, La			11011	enaker	18 Mother	's Name (F	irst, Middle,	Maiden Surname)	Home	<u> </u>
21215-0036 uld be filed within 7 Mental Hygiene marked other than	ent, t	al	Harold Edward Ca					Geor	gette	e Jose	phine 0'	Shaug	
D 27 should and Me	: Ē	۱۹	19a. Informant's Name/Relationship								mber, City or Town		,
P P TE E	traur	ł	Arthur Coates/Hu 20a. Method of Disposition		20b. Place of	of Disposit	ion (Name of ce			ad, Ki Date	dge, MD		
Baltimore, permit Pages   ar Department of Hes	or other		1 Burial 2 X Cremation			Ory or othe	atory,	Tnc	Q /1	7/06	Poltim	0.770	MD
Baltimo permit Page Department o	injury or	ŀ	4 Donation 5 Other Speci 21. Signature of Funeral Service Lice	ensee	Thecto	22. Na	me and Addres	s of Facility	Cre	nation	Baltim Society	of M	D. Inc.
		_	Fdward A. Grego	prchik		29	9 Frede	rick	Road	Balt	imore. M	D 212	28
Physici /Medio			23a. Part I. Enter the disease, or confailure. List only one cause on	each line		ot enter the	e mode of dying	, such as ca	ardiac or re	espiratory arr	rest, shock, or hea		pproximate Interval Between Onset and Death
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uted	ransit		events resulting in death) Last	Due to (or as a consect d.	quence of):						- · - ·		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The retrificate has been stuned by the attending physician and To the Funeral Director: After this certificate has been stuned by the attending physician and	the burial - transit	edical	UNPENDED	AMENDED									
68760, ertificate be ding physic	. 00	ΣΙ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome		Feta	al death 3	Ectonic	pregnanc	·v	23d Date of Month	delivery Day	Year
Box 6 e death cer	tached for use	sicia	past 12 months?  1 Yes 2 ✓ No 9 Unkno	4 Pregnant at ti			er (Specify)		p - 5	,		Duj	Tour
D. Be the de	ched f	Physici	Part II. Other significant condition	9 Unknown	but not resulting	a in the un	derlvino cause	given in Pa	art L	23e Did to	obacco use contri	bute to the	cause of death?
P.O	de	ক্র					, ,				s 2 <b>V</b> No 3	_	_
Records, The law require	hould	Completed								24a Was			y findings available
Recc The lav	page 2	E I									ormed? d	leath?	2 No
of Vital Recoing Physician: The law	rector,	Be	25. Was case referred to medical examiner?	Tita-itali			26.Plac	e of Death	(Check on				
of Vij	ral din	P	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	t 2 ✔ ER/O	utpatient Time of In		Other		Home 5	Residence 6	Other:	
Division of Vital tale or Attending Physician: 15 after death	he funeral	Certification:	1 V Natural 5 Pending	(Month, Day, Yea	ar)	Time of Ing	,	Yes 2		od. Describe	now injury occurre	ea	
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Spital hours a	/ filled	G	4 Homicide determine	ned (Specify)						or Town, S			
To the Hospital within 24 hours		Medical		sician: To the best of my ner:On the basis of exami									use(s)
To the within	COU	Mec	29b Signature and title of certifier	and manner stated				se number			29d. Date signe		
			( Daintie	(eell)			O.C	.M.E.			August 13,	2006	
1		ŀ		no completed cause of de	. ,	4.5	L	1277			<u> </u>		
7		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
	Sta	10	31. Date filed (Month, Day, Year)	7 200 A SZ. Registrars	s signature	1	and B						

		•	For Stete Registrer	State of Marylar		tificate of			Reg. No.	16	25975
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath		3. Time of Death
	Physici		Daniel Cul	ver		•		Month 08	Day	Year OG	1325pm
	/Medic Examin		4a. Facility Name (If not institution, give	<del></del>		4b. City, Town, o	or Location of Deat		4c. County		
	Examin	er	Burton Center			Balti					
	Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthp	ace (State or Foreign
	Funeral Director			<b>x</b> □M 2□F 53		Months Days	Hours Min.	Dec. 1	th ly, Year) 6,1952	Coun	
			Usual Residence of Decedent						7		
	ylenc wor		10a. State 10b. County		ity, Town or Lo	cation				10	Od. Inside City Limits
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	the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	3a.o	0	432 Margaret	Ave.		21	221		USA		
	ter death	Funeral	11. Marital Status	12. Was Decedent Ever in L	J.S.   13. 1	Was Decedent of I	Hispanic Origin? (S	pecify Yes or No		e - Americ	
(0	rite	Fur	1X Never Married 2 ☐ Married	Armed Forces? 13X Yes 2 □ No			an, Mexican, Puer	to Rican, etc.)		k, White,	
93	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐xNo	Specify:		Specify	·Whi	te
21215-0036	72 hours after death with the Marylend naturel', or Items 23s or 28s-f show likal Examiner must be notified at	Completed	15. Decedent's E		16a. Dece	dent's Usual Occup	pation	atria a	16b. Kind of Bu	siness/Ind	lustry
7	within 7 ene. than *n	pie	(Specify only highest gri	College (1-4or 5+)	life.	DO NOT use retire		rking	Medio	cal	
21	d wit	тo	12th		Nurs.	ing Ass	istant				
D	e filed withln al Hygiene. I other than vent, the Me	Ø.	17. Father's Name (First, Middle, Last	)			18. Mother's Na	me (First, Middle	, Maiden Sumam	ie)	
Maryland		To B	Floyd Culver				Betti	e Shue			
ary	should I and Meni is marke		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Numb	er, City or Town,	State, Zip	Code)
	1 and 2 Health a tem 27 is		Bettie Culver	/mother	et Ave.	Baltir	nore MD	)			
more,	f Hei		20a. Method of Disposition	20b.	ce)	Date	20c. Location -		wn, State		
no	Pages nent of int: If it		1 Burial 2 Cremation 3 C  1 Donation 5 Other (Speci	Hemoval from State   R	tory 8/	16/06	Baltim	ore	MD		
Ē		1	21. Signature of Funeral Service Lice		1 22	. Name and Addre	ess of Facility				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, 2. Date of Death 3. Time of Death Day **Physician** 0:09 AM -16-2006 /Medical hame If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore owsor ent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, 7. Age (In yrs. last birthday **Funeral** 213-28-923 1 🗆 M Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town of Lacation 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 905s. 1 No 2 □ No attimore Funeral Director 10f. Zip Code 10e. Street and humber 10g. Citizen of What Country? 06 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry Seconda ary (0-12) College (1-4or 5+) anage 17. Father's Name (First, Middle Lest, Mother's Name (First, Middle ins 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory orlother) Date 20c. 1 X Burial 2 Cramation 3 Removal from State 5 (Other (Specify) and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician ean reas /Medical Due to as a consequence of) Examiner Sequentially list conditions, it any, learning to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or se a noneequariou of): by Physician/Medical Examiner as the burial-transit Hospitel or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ours efter death. heral Diractor: Alter this certiticete has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours el To the Funeral D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hugust 16, 2006 200 und

13 State

Registrar

6701 N. Charles 31. Date filed (Month, Day/Year) AUG 1 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Aegistrar's Signature

DHMH 17 Rev 1/2001

Balto und

# Please Type or Print in Black Indelible Ink

varim Cross		State of Maryland / Department of Health and Mental Hygi  1- For State  Certificate of Death	Reg. No OGOC DCOT
Physician	n/	1. Decedent's Name (First, Middle,Last)	Date of Death 3. Time of Death 3
Medical Examin		4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	Month Day Year 0355 hrs 4c. County of Death
M make		University Hospital Baltimore	
Funeral Director		213.02.9085 1 MM 2 F 27 Yrs. Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
any	L.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
land f show	ខ្ន	MD Baltimore RandallStam  10e. Street and Number 10f. Zip Code	1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene int: If item 27 is marked other than "natural", or items 23a or 28a-f show any r other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	3807 HemoRd 21/33	10g. Citizen of What Country?
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ours afi atural' xamine	g P	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry
36 nin 72 h ihan "n dical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-00 led with Hygiene other	S	17. Father's Name (First, Middle, Last)  4 Years Workhouse Supervisor 18 Mother's Name (Fir	rst, Middle, Maiden Surname)
ore, MD 21215-0036 ss I and 2 should be filed within 7 of Health and Mental Hygiene If item 27 is marked other than ther traumatic event, the Medica	일 일	Jack Cross, Jr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	Allen
e, MD 2 l and 2 shou Health and l item 27 is r r traumatic	⊢ (	Linda Cross / mother 3807 Nemo Rd. Randalls	Hain MO 21133
nore, ages l and nt of Heal nt: If iten other tra		20a Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date of Disposition (Name of cemetery, crematory or other place)	ate 20c. Location - City or Town, State
	-	4 Donation 5 Other Specify  21.Signature of Funeral Service Licensee  22. Name and Address of Facility  (Cut.)	20010 Baltimore, MD Juan C. Greene Junion 1 Service Stown MD 21133
Balti permit Departu Import injury			
Physician /Medical		23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resfailure. List only one cause on each line.	spiratory arrest, shock, or heart  Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Stab Wound of Abdomen  Due to (or as a consequence of):	Bodii
~~	۳	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
and transit	ŭ.	d d	
760, craft physician and the burial - transit	Medical	UNPENDED AMENDED	
6876 ertificat ding ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
Box 687 e death certifice the attending p red for use as th	Physician/	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	
that the d	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ds, Fequires	ted		1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
ecor	Completed	\\	autopsy prior to completion of cause of death?
al Reian: The	မ္တို	25 Was case referred to medical 26 Place of Death (Check only	1 Yes 2 No 1 Yes 2 No
Physical Physical Carthis of Trail direction	의	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursing Ho  27. Manner of Death  28a. Date of Injury 28b. Time of Injury 28c Injury at Work? 28d	ome 5 Residence 6 Other:  d Describe how injury occurred
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death and Director: After this certificate has been signed by lied in by the funeral director, page 2 should be deach	Certification:	1 Natural 5 Pending Aug 13, 2006 0000 hrs 1 Yes 2 № No	bject was stabbed
ivision  I or Atten after death Director:	ti fica	Suicide Could not be	f. Location (Street and Number or Rural Route Number, City or Town, State)
Lospital Hours Tuneral		29a Certifier , a	22 Liberty Road, Randallstown, MD
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due when the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	
	Ž	29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d Date signed (Month, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	August 14, 2006
10		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201
Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 2006 32. Registrar's Signature	
	_	The second of the second	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For Stete Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2006 -HENOWETH 4:05PM 146US7 /Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE WASHINGTON NEDICAL GLEN BURNLE
If Under 1 Year If Under 24 Hrs. ANNE. HRUNDEL ENTER 5. Social Security Number 219-28-846-3
Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplece (State or Foreign **Funeral** Months Days Min 1 □ M 2 🖼 3 Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other then "neturel", or iteme 23a or 28e-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2106 2.3.4. DR. 2 should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ¶o Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced STINK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Je, Maryla.

Jer, Maryla.

Jer, Maryla.

Department of Heelth and Merimportant: If item 27 ieny injury or other. RITTER VIRGINIA KEARNS HARVEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Na e/Relationship (Type, Print) Than Charles J. DR GENBURNE, MD.

Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -18-06 4 □Donation 5 □Other (Specify) HANDNER Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): Examiner anding physicien and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 10 Due to bas a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | cete has been signed page 2 should be det Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 🗌 Yes 21 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 papatient 2 ER/Outpatient 3 DOA this. After this funeral d 28a. Date of frijury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director:, completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) ů, 29b. Signature and title of certified Name and address of person who completed cause of death (frem 23a) (Type, Print) MO 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrer	4	State o	f Marylan	d / Dep		nt of H	ealth a	and M	lental Hy		200	6	259	79
	Physici	an	1. Decedent's Name	e (First, Middle, L	_ast)	Chic	a ma					2. Date of De Month	Day	Υ	ear	3. Time of Dea	
	/Medic	cal	HEIEN 4a. Facility Name (II	f not institution, a	rive street and nu	Chyl	טוון(	4b. City.	Town, or	Location of	of Death	08	15 4c.	20 County of		9:03 AsH	M
	Examin						ter		sed	4	or Doute.			Balti		re	
	Funeral		Franklin 5. Social Security N		Sex 1 □ M XOXF				r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bir 7 – 12 –	nth ay, Year)	9	. Birthp	lace (State or Fo	oreign
	Director		169-18- Usuel Residence of		1	8	3 Yrs.					/-12-	1923		MAI	RYLAND	
	inyland		10a. State MD	10b. County	LTIMOR	1	y, Town or L	ocation	D.(	CHD	A T 17				1	Od. Inside City L	
	the Ma 28a-f	ecto	10e. Street and Nur		TITIMOK	-		10f. Zij		DSEDA	4LE		10a Citi	zen of Wha	at Coun	1 Yes 2	Ž 140
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	ems 2	Inera	11. Marital Status		Armed Fo	edent Ever in U.	.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - Black,			
36	rs afte	by Fu	1 ☐ Never Marri 3 🕅 Widowed	ed 2 Married 4 Divorced	1 ☐ Yes If Yes, Giv Year or D	/ <del>0</del>		1 🗆 Yes		Specify:				Specify:		HITE	
9	2 hou	ted		15. Decedent's	Education		16a. Dece	dent's Usu	al Occupa	ation	t of worki	na	16b. Ki	nd of Busin	ness/Inc	dustry	
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Helen	Hygier ther ti	S	17. Father's Name		st)		пО	MEMA	KEK	18. Mothe	or's Name	(First, Middle	. Maiden	OWN Sumame)	HOM	1E	
1an	Aental rked o	To Be	MICHAE			MISIEJ	KIS				INA	,		KOBA	LSF	(I)	
Chromo, Helen Baltimore, Maryland 21215-0036	12 should h and Men 7 ie marke reumatic		19a. Informant's Na PAUL CH					ing Address				I Route Numb		r Town, Sta LE ,		<sup>Code)</sup> 21237	,
re,	s 1 and f Healt item 2: other t		20a. Method of Disp	position		1 6	Place of Disperentery, cre	osition (Na	me of	1		)ate		cation - Cit			
2 <u>E</u>	Pages ment of ent: if it ury or o	18		☐ Cremation 3 5 ☐ Other (Spec	☐Removal from cify)	SIAIA	RDENS	-			8-1	8-2006	BAL	TIMO	RE,	MD	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hyglene. Importent: if Item 27 ie marked other than "naturel", or items eny injury or other treumatic event, Tra Medical Expullier in once.		21. Signature of Fu	neral Service Lic	ensee							CH/ROS NUE R				RAL HOM 21237	
	Physician		23a. Part1. Enter the shock, or heel Immediate Cause (disease or condition resulting in death)	rt failure. List on Final	mplications that only one cause on e	ach line.	h. Do not en Uteri					or respiratory a	rrest,			Approximate Interval Between Onset and Dear 7 do US	
	/Medical Examiner			1		(or as a conseq	uence of):									J	
	p is	iner	Sequentially list confrant, leading to in cause. Enter Unde Cause (Disease or that initiated events)	nditions, imediate irfying	b. Due to	or as a conseq	uerice of).										
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x 68	leath certificat attending phy I for use as th	/Med	IF FEMALE:		220 Have out	come of pregna	nm										
P.O. Box	that the death c ned by the attend detached for us	Physician/Med	23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 Live b	irth 2 ☐ Feta ant at time of d	I death 3[	⊒Ectopic p ⊒ Other (s)						23d. Date of Month		ny Day Year	, ,
ords, P	The law requires thet the death certifica ete hes been signed by the attending ph page 2 should be detached for use as th	þ	Part II. Other signif	icant conditions	s contributing to d	eath but not res	ulting in the u	inderlying (	ause give	en in Part I				se contribu ∃No 3(		e cause of deatl	
Division of Vital Records,	: The law r cete hes be page 2 sh	Completed										24a. Was auto perfe 1 ☐ Yes		prio	r to con	osy findings avai npletion of cause 2 No	ilable e of
Vits.	ysician: Th is certificete director, pag	Be	25. Was case reference examiner?		Hospital:				Othe			Check only					
ð	Phys er this eral di	7: To	1 ☐ Yes 2 ☐ 27. Manner of Deat	•	A	npatient 2 of Injury th, Day Year)	28b. Time o		28c. Injury	at		ne 5 Res 28d. Describe			(Specify	′)	
ion	Attending Physician: r deeth. ector: After this certifice by the funeral director.	ation	1 Natural 2 Accident	5 Pending investigat	ion	th, Day Year)	Injury	М	Work 1 □ \	<br Yes 2 □	No						
Divis	after de Directo	ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	289. Place	of Injury - At ho ng, etc. (Specif	ome, farm, st	reet, factor	y, office			28f. Location ( City or To	Street an wn, State	d Number	or Rura	l Route Number,	
	To the Hospitel or Attent within 24 hours after deeth To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one)	1 Certifying I 2 Medical Ex	Physicien: To the eminer: On the band man	best of my kno asis of examina ner stated.	wledge, deat	th occurred evestigation	at the time, in my op	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and mann place, and	er as st due to	ated. the cause(s)	
	To the vithin 2 To the complet	Me	29b. Signature and	title of certifier				29	c. License	number			29d. Dat	e signed (/	Month, I	Day, Year)	
			<b>)</b>	VY	MD				AF2	328	1124	303	0	3/15	120	Olo	
	7		30. Name and addr Dr. Tiffau 31. Date filed (Mon	ess of person wh	etos Mr	e of death (Item	Type	Print)	110-	o Dai	, D	Ca. 143	202 1	UN 2	ו בכנו	7	
	Sta Registi	are.	31. Date filed (Mon		9	egistrar's Signa	iture	117 39	war	וויועש	, 0	<u>wiiim</u> (	11 6 1	ID A			
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			For State of Registrar	Maryland / [	Department of F Certificate of			ene2006	25980
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Dorothy M. Cotter			:	2. Date of Death Month	Day Year	3. Time of Death
	Exami Funeral Director		4a. Facility Name (If not institution, give street and number of the st	Age (In yrs. last bir	al R05	Hours Min.	3. Date of Birth (Month, Day, ) Jan . 19,	4c. County of Death Position (ear) 9. Birth Cou	place (State or Foreign
	death with the Maryland ime 23a or 28a-f show f must be neillied at	ctor	10a. State 10b. County N/A	10c. City, Town Balti					10d. Inside City Limits Yes 2 □ No
7	th with the 23a or 28 ast be no	al Director	10e. Street and Number 507 W. 27th Street		10f. Zip Code 21.	211	100	g. Citizen of What Cou USA	ntry?
子(3036	72 hours after death with the Maryls "natural", or iteme 23a or 28a-f sho odicel Examiner must be notilified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deced Armed Forc  1 Yes 2  If Yes, Give Year or Dati		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		ify Yes or No- ican, etc.)	14. Race - Ameri Black, White Specify: Wh	
) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	hin 72 h	pietec	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation during most of working d)	16	6b. Kind of Business/Ir	idustry
nd 21	e filed wit at Hygiene I other the vent, Inc.	Be Completed	17. Father's Name (First, Middle, Last)	(10)	Office Cler	18. Mother's Name (		Media Mate	rials
ER,	should but Ment marked	7	James F. Ryan  19a. Informant's Name/Relationship (Type, Print)	196.	. Mailing Address (Street	Helen E.		City or Town. State. Zi	o Code)
H, W.	1 and 2 Health a em 27 ie		Debrie Uhrig Daughter  20a. Method of Disposition		511 W. 27t	th Street,	Baltimo	ore, Maryla	ınd 21211
( ∪ \	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other fraumatic event, ITE M. 2016.		1 ☐ Burial 2XX remation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature #Funeral Service Licensee		Disposition (Name of y, crematory or other place Crematory  22. Name and Addres Burgee Her	8/18/2	2006 Ca	tonsville,	Maryland
	40 E E a		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	ised the death. Do n	3631 Falls	Road, Bal	timore,	Home, Inc. Maryland	Approximate Interval Between
8760, 🗸	Physician be executed by Additional Base the burial-transit as the	edical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or	as a consequence of as a consequence of the sequence	S				
Division of Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certifics liter death. Director: Atter this certificate has been signed by the attending of in by the funeral director, page 2 should be detached for use as it.	Physician/Med		n 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
rds, P	w requires tha been signed I should be det	<u>آخ</u>	Part II. Other significant conditions contributing to deat	th but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to to	he cause of death? pably 4 Unknown
al Reco	itcian: The law re certificate has be rector, page 2 sho	Completed					24a. Was an autopsy performe	d? prior to co death?	opsy findings available impletion of cause of
of Vit	ding Physician: The n	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No Hospital: 1 Inp	atient 2 ☐ ER/Out	patient 3 DOA Othe	26. Place of Death (text)  er: 4 □ Nursing Home		e 6 □Other (Specif	 γ)
sion o	tending Pr feath. tor: After th	Certification:	2 Accident investigation	Day Year) In	njury Work M 1 ☐ `		d. Describe how		
Divi	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certifi	determined 288. Place of	Injury - At home, far , etc. (Specify)	m, street, factory, office	280	Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)  1. Certifying Physicien: To the be said and manner  1. Certifying Physicien: To the be said and manner	s of examination and	death occurred at the time. death occurred at the time. death occurred at the time.	ne, date and place, and pinion, death occurred	d due to the caus at the time, date	se(s) and manner as s and place, and due to	lated. o the cause(s)
	6-	M	29b. Signature and title of certifier		29c. License D 5	4736	29d.	Date signed (Month,	Day, Year)
	Sta Registr		30. Name and address of per in the completed cause of DR. Kong Yul August 31. Date filed (Month, Day, Year)  AUG 1 7 2006	6		Zlin oq. di	2 Balt	IMORE, WI	31237
DH	MH 17 Rev 1/2	001		OR	RIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend mitem 8 per fh 23b per doc 8858 8-17-06 vt State of Maryland / Department of Health and Mental Hygiene) (1)

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year AUGUST 10,2006 9:05 A M Edse1 Ardean Docken, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Man of Birth Manth, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 215-74-6931 50 Yrs. **Director** Germany Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Dulaney Gate Court 21030 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: USA 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other tt
any injury or other traumatic event, the 4 Commercial Lender Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edsel Ardean Docken, Sr. Helen Jane Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Baker Docken/Wife 8 Dulaney Gate Court Cockeysville, MD 21030 20b. Place of Disposition (Name of Cemetery Crematory or other place)
Metro Crematory Aug. 15, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Baltimore, MD Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 26 Signature of Funeral Scholce Licens Bryan W. Clary 23a. Part1. Enter he d sease, or complications that caused shock, or "eart failure. List only one cause on each line e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate C use (Fina disease or condition resulting in death) Physician CARDIOPULMONARY ARREST 60 MIN. /Medical Due to (or as a consequence of) Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 Physician/Medical is certificate has been signed by the attending phys director, page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 TYes 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 08,10,2006 no D 0064040 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD TEMPEL M. D. 7601 OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 7 2006

**ORIGINAL** 

		1	State Registrar			of Health and N	Лental Hyg ве	iene) (	)6 25982
	sicia edica	n il -	1. Decedent's Name (First, Middle, Last) Charles Benjamir				2. Date of Death Month	Day 13	Year 6.30 PM
Exa Fune Direc			Baltimore VA Medica  5. Social Security Number  6. Sex	Center 7. Age (In yrs. last birth	Ba [	wn, or Location of Death Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth	4c. County o	9. Birthplace (State or Foreign
D D			Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	re	Jan «I	1 1 1	10d. Inside City Limits 1 XYes 2 □ No
eth with the		<u> </u>	1704 Presstma	n St.	10f. Zip 0	01217		g. Citizen of Wi	SA
ours atter de		ਨ∣	11. Marital Status  1 □ Never Married 2 ▼ Married  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was DecerAmmed For 1 ▼ Yes, Give Year or Da	2 □ No	13. Was Decede	nt of Hispanic Origin? (Sp Cuban, Mexican, Pueric Do Specify:	ecity Yes or No- Rican, etc.)		- American Indian, , White, etc.
ified within 72 hours atter deeth with the Maryland Hygiene. Hygiene a star of itame 23e or 28e-f show		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-		1 21	Occupation done during most of work retired)	sing	6b. Kind of Bus	Huminum Co
hould be file d Mental Hy marked other		lo ge	17. Father's Name (First, Middle, Last)  Charles  Dav  19a. Informant's Name/Relationship (Type, Print)	5	Mailing Addrage /	18. Mother's Nam	e (First, Middle, N	Gro	SS
perillingtey, Index yiellin 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked of other than "natural, or Itame 23a or 28a-f show any Inter or 20 the trains of other than "natural", or Itame 23a or 28a-f show the trains of other trains.			MrS. Grace Davis  20a. Method of Disposition  1 Ø Burial 2 □ Cremation 3 □ Removal from S	20b. Place of	Disposition (Name r, crematory or oth	sstman	St. Z	Balto.	rate, Zip Code)  1 2 2 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1
permit. Pa Depertment Importent	Suc.		4 Donation 5 Other (Specify)  21. Significant of Funeral Service Licensee	_ Garri USS	Joseph 2722 V	Address of Facility L. KUSS F	s/2006 ( funeral ve. Ba	Home Home	P.A. 21216
Physici /Medic			23a. Part Enter the disease, or complications that a shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)  Due to (c	cn line.	with unk	of dying, such as cardiac			Approximate Interval Between Onset and Death
te be executed SX		cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence o					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Attent this certificate has been signed by the attending physician and commissed filter in the funeral director, nane 2 should be described for use as the funial transit		- Med	in the past 12 months?	ome of pregnancy th 2  Fetal death int at time of death wn	3 □Ectopic preg			23d. Date Mont	The state of the s
quires that I		<u>`</u>	Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying cau	se given in Part I.	23e. Did tob		oute to the cause of death?
The law receipt has been		Completed					24a. Was an autopsy perform	ed? pri	ere autopsy findings available or to completion of cause of ath?
Sician certiti		ן מ	25. Was case referred to medical examiner?  Hospital:			04	h (Check only one	7.5	
eath.  or: Atter this be tuneral of		Ceruncation: 10	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation (Month	, Day Year) In	me of 280 jury M	Injury at Work?	ome 5 ☐ Resider 28d. Describe hor		
spital or Att ours after do lerat Direct			3 Suicide 4 Homicide  6 Could not be determined  28e. Place obtained  29a. Centifier  1 Certifying Physician: To the leading to the lead of the lead o	of Injury - At home, faring, etc. (Specify)	· ·		City or Town,	State)	or Rural Route Number,
n 24 h		Medical	(Check only 2 Medical Examiner: On the ba.	sis of examination and	or investigation, in	my opinion, death occur	red at the time, da	te and place, an	d due to the cause(s)
Within To t	1			resident		17412	1	,	Month, Day, Year)
	State		31. Date filed (Month, Day, Year) 32. Re	reene St. gistrar's Signature	Baltimore	MD	<del></del>		
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				OF	RIGINAL				

		For State Registrar	State of Ma			ate of l			Reg.	4-	UU	259	U
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/Medic	_		Violet Dolk					August		2006		5:13	Рм
xamin	er	4a. Facility Name (If not institution, gi			4b. C		r Location of De impnium	ath		4c. County	of Death Balt	imara	
		Stella Maris 5. Social Security Number 6.		(In yrs. last birtho	nav) If Ur	nder 1 Year	If Under 24 H	rs. 8. Date of	Birth			place (State or F	Foreign
ineral rector			1□M 2K□F	82 Yr	Mont	ths Days	Hours M	in. (Month,	Day, Ye	923	Cou	/land	or orgin
22-2		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	a Lanatina							IOA Innida City	1 (
	5											10d. Inside City 1 ☐ Yes 2	
riomies at	Director	Md. House	ird			tt City	У		100	Citizen of V	Mhat Cau		
1 1			C		101.		1042		iog.		ISA	illuy:	
	Funerai	12633 Faun Run	12. Was Decedent E	ver in U.S.	13. Was De			(Specify Yes or erto Rican, etc.)	No-			can Indian,	
		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No	0				erto Rican, etc.)		Blac	ck, White,	etc.	
	l by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ∐ Ye	s 2XINo	Specify:			Specify	y:	White	
	etec	15. Decedent's E (Specify only highest gi		16a. D	ecedent's ( Give kind of	Usual Occupa	ation during most of w	vorking	16b	. Kind of Bu	usiness/In	dustry	
e Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	•)					5				
or other traumatic event, the Ma	ပိ	17. Father's Name (First, Middle, Las	4	111	merior.	Design		lame (First, Mid		mitur		πe	
•	Be c						10. 1000101311			_	10/		
mat	၉	19a. Informant's Name/Relationship		19b. M	lailing Addr	ress (Street a	and Number or	Mandi. Rural Route Nur		ssari.	State. Zir	Code)	
T.	1	Mrs. Nancy A. Kipke/D						llicott C					
othe	1	20a. Method of Disposition		20b. Place of D	isposition (	4144		Date	-	. Location -			
יל סל		1 Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		Dulaney V	٠.	' <b>_</b>	·	8/06	Tin	nonium,	Mery.	land	
any injury or our		21. Signature of Funeral Service Lice	9600	6				Lick Towso			bome, I	Inc.	
e a		Michael	1 Tursif			York Ro		on, Maryl		21204			
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line	he death. Do not b.	enter the r	mode of dyin	g, such as card	iac or respirator	arrest,			Approximate Interval Betwee Onset and Dea	
an al		Immediate Cause (Final disease or condition resulting in death)	a. PNEUMON									J	
er			Due to (or as a	consequence of)									
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of).	:					-			
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rial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):									
the buria			d										
	Aedi	IE ECHALE.											
no noe as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months?	23c. If yes, outcome o		3 □Ectopi	ic pregnancy					te of delive	•	
ĺ	sici	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown		5 Other				-	Mo	ករោ	Day Yea	ır
detached	Phy	Part II. Other significant conditions	contributing to death but	not reculting in th	a undark	00.001100.00	on in Do⊲ I	220 0	d tobacc	no use cost	ribute to "	he cause of dea	162
90 90	þ	. a.t other digitalicant conditions	commodering to abatif but	. not resulting in tr	io unu <del>u</del> niyir	ny cause give	en III Falti.			2 No			
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or, page		OF Was some interest to seed to					Notice to the second	1 ☐ Ye	2 💢		Yes	2□ No	
director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 ☐ Inpatien	4 C C C C C C C C C C C C C C C C C C C	-tt 0C	Othe	ne:	eath (Check on					
funeral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day		e of	28c. Injury Work	4 LI Nursing	Home 5 ☐ Re 28d. Descrit				) HOSP	LCE
5	atlo	1X Natural 5 ☐ Pending 2 ☐ Accident investigation		Yea <i>r)</i> Inju	ry M		Yes 2 □ No						
r d	Certification:	3 Suicide 6 Could not l	286. Place of Injur	y - At home, farm	, street, fac	ctory, office		28f. Location	(Street	and Numb	er or Rura	I Route Number	r.
eletely filled in by the fu	Cert	# I Homicide	building, etc.	(эрвспу)				City or	Town, St	ia(θ)			
ly till	edical (	29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of e	my knowledge, d	eath occur	red at the tim	ne, date and pla	ce, and due to the	ne cause	e(s) and ma	nner as s	tated.	
	ğ	one)	and manner state	ed.				at tile till		anu piace, a		ule cadse(s)	
ompletely	ž	29b. Signature and title of certifier				29c. License				Date signed			

Registrar
DHMH 17 Rev 1/2001

State

5:13 p.m.

AUGUST 14, 2006

AINI DOLK

TIMONIUM, MD 21093

2300 DULANEY VALLEY

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2
31. Date filed (Month, Day, Year) 7 2006

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f shov

the Medical Examiner must be

Department of H
Important: If its
sny injury or ot
once.

Priysician

Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

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after death.

I Director: Aft in by the fur

within 24 hou

To the Fune

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Hospital 24 hours a

filled in by

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Director

Completed by Funeral

Be

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Examiner

Completed by Physician/Medical

Be

Medical Certification: To

29a. Certifier

(Check only

10e. Street and Number

1 Never Married 2 Married

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 □ Donation 5 □ Other (Specify)

21. Signature of Juneral Service Licensee

Daniel J. Tyler

6348 Frederick Road, Rm 109

15. Decedent's Education (Specify only highest grade completed)

Karen J. Finnegan - Daughter

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

the Maryland

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ②No If Yes, Give Year or Dates:

College (1-4or 5+)

2. Date of Death 3. Time of Death AUGUST 1625 M 2006 4c. County of Death

N/A Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits

1 ☐ Yes 2√☐ No

Approximate Interval Between Onset and Death

10g. Citizen of What Country?

21228 United States

Reg. No.

14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

White Specify 16b. Kind of Business/Industry

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk Bakery

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Bromwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1321 Elm Road, Baltimore, MD 21227

20b. Place of Disposition (Name of Meadlow related) Memorial Park 8-18-2006 Elkridge, MD

Date

22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

EREBELLAR BLEED

Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

Due to (or as a consequence of): HYPERTENSION

DAYS UNKNOWN

20c. Location - City or Town, State

Due to (or as a consequence of):

Due to (or as a consequence of)

resulting in death) Last

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

10f. Zip Code

1 ☐ Yes ♣☐ No Specify:

23d. Date of delivery Day Month Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY OBSTRUCTIVE DISEASE 23e. Did tobacco use contribute to the cause of death? 2X No 3 ☐ Probably 4 ☐ Unknown 1 Tes

24a. Was an autopsy performed? Yes 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number fralue, MD

29d. Date signed (Month, Day, Year) DO054257 AUG 14th 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. SHARMA . ST. AGNES HOSP.

CATON AV. BALTIMORE, MD 900

State

Registrar

31. Date filed (Month, Day, Year) AUG 1 7 2006 32. Registrar's Signature Cooke Carred A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 13 per fh 9858 8-17-06 vt.
State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 32000 22 **Physician** Edvardo (jome /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** Columbia Columbia Loward LURIEN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Oct. 13, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Yrs. 1938 Nicaragua 67 Director 220-43-2695 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County r than "natural", or Itema 23s or 28s-f ehow the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director Germantown Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19753 Crystal Rock Drive 20874 Nicaragua 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1⊠Yes 2□ No Specify: 3 AWidowed 4 ☐ Divorced Hispanic Hispanic 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Farmer Farming permit, Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 271s marked other It any injury or other traumatic event, Ita 2006. other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josefa Berrios ၉ Porfirio Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e of Disposition (Name of Date Date 20c. Location - City or Town, State Faber Gomez - Son 20a. Method of Disposition
1 □ Burial 2 A Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 □ Donation 5 □ Other (Specify) Aug. 16, 06 Baltimore, MD Metro Crematory 21. Signature of Funeral Service Fensee <sup>2</sup>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) metastatic Carcinoma of **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Chronic respiratory failure-ventilator 1 Pres 2 No 3 Probably 4 Unknown Portabetructive proumonia 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? liver and spine mets 1 ☐ Yes 2 ☐ No : After this certifical funeral director, f 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♠ No 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100000483 mpleted cause of death (Item 23a) (Type, Print) 305 Nospitel Dr. Glen Burnie, MD JACOBS mn 31. Date filed (Month, Day, 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2006

			1 - For State Ragistrar	State of Ma	-	•	of Health			iene og. No.	06	259	386
	Physicia	on.	1. Decedent's Name (First, Middle, Las	t)			-		2. Date of Deat Month	h Day	Year	3. Time of	Death
	/Medic		John William Grov						08/15	1		2:33	a.M
	Examin	ier	4a. Facility Name (If not institution, give	street and number)			Town, or Locatio	n of Death		4c. County	of Death	_	
3	Funeral	200	5521 Link Avenue 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birtho			er 24 Hrs.	8. Date of Birth (Month, Day,			e place (State of	or Forei <b>an</b>
	Funeral Director	2		QM 2□F	72 Yrs	Months	Days Hours	Min.	(Month, Day, 5/20/3			rylanc	
pg	<b>&gt;</b> 283		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	Location			<del>3/20/3</del>			Od. Inside C	
laryla	e hov	ō	MD Baltir	nore	Haletho								2√ No
the A	28a-i	rect	10e. Street and Number		11010011	10f. Zip	Code		11	Og. Citizen of	What Cou	ntry?	
h with	3a or	Ö	1823 Woodside Ave	enue -		2	1227			USA			
deat	ama 2	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	3. Was Decede	ent of Hispanic ( ify Cuban, Mexic	Origin? (Spe	ecify Yes or No- Rican, etc.)		e - Americk, White,	can Indian,	
s after	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 💢 N	0	1 ☐ Yes 2			, , , , ,	Specif		ite	
3-0030 72 hours after death with the Maryland	fural al Ex		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a De	cedent's Usual	LOccupation			16b. Kind of B			
7 nin 72	n "na Medic	Completed	(Specify only highest gra		(G	ive kind of won e. DO NOT us	k done durina m	ost of worki		shingta		,	
d wit	giene er the	mo.	Elementary/Secondary (0-12)	College (1-40) 34		Supervi	sor		\$	nitary (	aimis	sian	
	d oth	Be	17. Father's Name (First, Middle, Last)						(First, Middle, A	Maiden Suman	ne)		
Via ould !	Men	7	Alexander Groves					Eva Be					
Mar d2sh	h and 7 Is n treun		19a. Informant's Name/Relationship (7			-			ul Route Number,		State, Zip	Code)	
and a	Healt tem 2 other		Shelby Florey/dat 20a. Method of Disposition	ignter	20b. Place of Di	sposition (Nam	e of	1	oate MD	ZIZZ/ 20c. Location -	City or To	own, State	
ages	ant of at: If I		1 ★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Meadowrid	je Menori	al Fark	8/17	7/06	Elkrido	re M	arvlan	ьд
Dallimor bermit. Pages	Department of Health and Mental Hygiene. Important; or Itema 23a or 28a-f ehow Important: If Item 27 is marked other then "natural", or Itema 23a or 28a-f ehow ary injury or other treumatic event, the Madical Examinat must be notified at once.		21. Signature of Funeral Service Licen				d Address of Fac	cility	<del>-'</del>		je, m	aryıaı.	.u
o š			mpy			Gary L.	Kaufmen E	uneral	Home @ M	P, Inc.	2 2107	=	
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused one cause on each line	the death. Do not e.	enter the mode	of dying, such	as cardiac o	or respiratory arre	est,	1 2107	III terval bet	ween
	ysician		Immediate Cause (Final disease or condition	a. to	rm.nd	Chron	· c 065	huder	e pulma	y dis	ease.	Onset and	Death
	Medical caminer		resulting in death)	Due to (or as a	consequence of):					/			
	*	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):								
g. 3	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
be executed	an an irial-tr	Еха	resulting in death) Last		consequence of):								
ate	been signed by the attending physician and should be delached for use as the burial-transit	dicai	•	d									
€ ۵	ding p	/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy					201.5	( . )		
DOX eath cer	atten I for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pre					te of delive onth	,	Year
i g	ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown			,,						
s tha	gned beet	<b>by</b> P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	e underlying ca	use given in Pa	rt I.	23e. Did tob	acco use con	tribute to t	ne cause of o	death?
ecords, law requires t	ould t			-					1 Te	s 2 No	3 Prot	ably 4	Unknown
la we	as be	Completed							24a. Was ar autops	y	prior to co	psy findings mpletion of a	available ause of
T Pe	s certificate has b director, page 2 s	Con							perform		death? 1 🗌 Yes	2 No	
Of VICAL Physician: T	certifi	Be	25. Was case referred to medical examiner?	Hospital:			Other		(Check only on			daudh	ter's
P Q	Ē a	To To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier  28a. Date of Injun (Month, Day)			Bc. Injury at		me 5 Reside		er <i>(Specit</i> red	y resid	ame _
nding	tth. :: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	i i	Year) Inju	M M	Work? 1 ☐ Yes 2						
UNISION or Attending	er des rector by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm	street, factory,	, office		28f. Location (Sti	reet and Numb	oer or Rura	I Route Num	ıber,
2 e	rs after	Cer			. (0,000.,7)					, 5.0.0)			
Hosp	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Madical Exan	ysician: To the best of ninar: On the basis of	examination and/o	eath occurred a r investigation,	at the time, date in my opinion, d	and place, leath occurr	and due to the ca ed at the time, da	iuse(s) and ma	anner as s and due t	tated. o the cause(s	<b>i</b> )
othe	thin 2 of the emplet	Med	29b. Signature and title of certifier	and manner stat		29c.	License numbe	er e	25	9d. Date signe	d (Month.	Dav. Year)	
ř	≥ ⊢ ŏ			P Kr	y hu		0310	6 1		8/13	//		
	10		30. Name and address of person who	completed cause of	eath (Item 23a) (Ty	pe, Print)	218	0 0		- / . /	/ 6		
	17		migr-00		4	16 E.	Tun	pa	Rel 7	ovsm	m	d 21:	204
	Sta Registr		31. Date filed (Month, Day, Year)  ALIG 1 7 2	32. Pegistra	r's Signature	1	0 11		Rel T				
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			For	State of Maryla		artment of Health		ntal Hygien	e o o o	55007
			1 - State Registrar		Cei	rtificate of Death		Reg. N	6.000	2398/
	sicia		1. Decedent's Name (First, Middle, L	Mae CAI	iffin			Date of Death Month D	2006	3. Time of Death
	ledic amin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or Location			c. County of Death	0.10
			5. Social Security Number 6		s. last birthday)	59/time		Date of Birth	N/A 9 Birth	place (State or Foreign
Fune Direc	4		259-18-4166	1□M 2ØF 82	Yrs.	Months Days Hours	Min.	Date of Birth (Month, Day, Yea ) CC. 12, 1	923 8	eorgia
land			Usual Residence of Decedent  10a. State 10b. County	j 10c. (	City, Town or Lo	cation				10d. Inside City Limits
e Mary a-f eh		ctor	Maryland N	'/A	Bal.	timore				1 OYes 2 □ No
death with the Maryland ime 23a or 28a-f ehow	00 DI	Director	10e. Street and Number	To The	1 -	10f. Zip Code		10g. C	Citizen of What Cou	intry?
death me 23		Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispanic Or	) rigin? (Specif	y Yes or No-	14. Race - Amer	
.0036 hours after death with the Marylar turel; or Iteme 23a or 28a-f ehow			1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes, Give		If Yes, specify Cuban, Mexical  □ Yes 2 No Specify:		an, etc.)	Black, White	, etc.
15-0036 72 hours at "naturel", or	100	Completed by	15. Decedent's I	Education	16a. Dece	dent's Usual Occupation	at at warten	16b.	Kind of Business/Ir	adustry
within 72 ene. then "na	event, the Medical	mple	(Specify only highest g	College (1-4or 5+)	\ \langle \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	kind of work done during mos DO NOT use retired)	st of working	4	Mal	10/
filed v Hygie	eut, in	မ လ	17. Father's Name (First, Middle, Las	SI)	111.11	51119 / 155 18. Moth	er's Name (F	First, Middle, Maide	an Sumame)	Cay
<u>a</u> = = =	atic ev	To Be	Joe Haro	lison		Fre	anKi	e_Ta	ylor	
Mary d2 shoul th and M 7 le mari	trans.	G	19a. Informant's Name/Relationship	(Type, Print) (daughter	19b. Mailir	ng Address (Street and Numb	er or Rural P	Route Number, City	o Town, State, Zi	O Code)
C = N	other		20a. Method of Disposition	l .	Place of Dispo	sition (Name of natory or other place)	Date	9 20c.	Location - City or T	own, State
Pa Pa	injury or		1,  Burial 2  □ Cremation 3 4  □ Donation 5  □ Other (Spec		-butu	S Mem. Park	8/21/	2006 A	rbutu	S. Md.
Baltim permit. Pag Department Important:	eny in		21. Signature of Funeral Service Lice	SISSE RILL	JC	Name and Address of Facili	SS F	uneral	Home t	in.
1000	g.		23a. Part Enter the Asease, or consher, or heart filure. List only	mplic lions that as ed the de	ath. Do not ent	er the mode of dying, such as	s cardiac or r	espiratory arrest,	IVId. 217	Approximate Interval Between
Physic			Immedi e Cause (Final disease or condition resulting in death)	Oil	elero	1. 0		1	isease	Onset and Death
/Medi Exami			resuming in doubly	Due to (or as a conse	equence of):	ure				J
<b>D</b> :	1	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse		01.11.1				
6U, be executed ician and	al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):	Mellitus		·		
y se	ing eu	Ca	(	d						
Geath certifica	se as	/Med	IF FEMALE:	23c. If yes, outcome of preg	nancy				22d Date of deli-	
the death certificaty the attending ph	101 be	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	Day Year
Hecords, P.O. The law requires that the ste has been signed by the	etache	Phys	9 ☐ Unknown * Part II. Other significant conditions	9☐ Unknown	eculting is the u	adorhing asses asses in Part		23a Did tobacco	. use contribute to	the cause of death?
COTOS, P w requires that been signed t	eq pi	d by	ratin. Other significant conditions	contributing to death but not re	rsulling in the b	ndenying cause given in Fait	1.	1 Tes		bably 4 DUnknown
Hecords, he law requires t e has been signe		Completed						24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
	, page	Con						performed? 1 ☐ Yes 2 ☑ N	death?	2 <b>A</b> No
	director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2[	TER/Outpatier	Other		Check only one)	6 ☐Other (Speci	4.1
	<u></u>	T:UC	27. Manner of Death 1 ∑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of			d. Describe how in		197
DIVISION  f or Attending after death.  Director: After	by the tu	catl	2 Accident investigati	be 280 Place of Injury At	home farm str	M 1 Yes 2		Location (Street	and Number or Rur	al Poute Number
Dirth o	d ri be	Certification:	4 Homicide determine	building, etc. (Spec	cify)	eet, ractory, office		City or Town, Sta	ite)	ai riodie riginoer.
5.45	Ξ	Medical (	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	Physician: To the best of my kraminer: On the basis of examir and manner stated.	nowledge, death nation and/or in	n occurred at the time, date an vestigation, in my opinion, dea	nd place, and ath occurred	due to the cause at the time, date a	(s) and manner as s nd place, and due t	stated. o the cause(s)
To the within 2	completely	Me	29b. Signature and title of certifier	and marinor dialog.		29c. License number			ate signed (Month,	
Arr			> Bonatan K	1 Malen 1		D 155	03	Hy	gust 15	52006
0	7		30. Name and address of person who	completed cause of death (Ite	5617	DOLPHINS	T, B	ALTIM	ISPE N	1D 213H
	Sta	te	31. Date filed, (Month, Day, Year)	32. Registrar's Sign	nature					

			1 - For State of Maryla		rtment of Healt		ntal Hygier	2006	25988
			Decedent's Name (First, Middle, Last)		,		Date of Death		3. Time of Death
	Physici /Medio		Vesta Cluss-	m	eacher	~	Month FUGUST	12,2006	833 am
	Examir		4a. Facility Name (If not institution, give street and number)	10	4b. City, Town, or Locat	tion of Death		c. County of Death	
			5. Social Seerlity Number 6. Sex 7. Age (In vis	pital	Sachmirk If Under 1 Year   If Ur	e Crander 24 Hrs. 8	Page of Birth	0.50	100
	Funeral Director		2316-33-7643	s. last birthday) Yrs.	Months Days Hou	ırs Min.	Date of Birth (Month, Day, Yea (Month, 192)	9. Birthp	lace (State or Foreign
2			Usual Residence of Decedent				7/16/198	7	
5	arylen show	_		City, Town or Lo				1	Od. Inside City Limits
3	he Mi	Director		Himor					1 Tes 2 No
$\varkappa$	with ti	吉	10e. Street and Number		10f. Zip Code			Citizen of What Cour	ntry?
,	after death with the Marylen or items 23s or 28s-f ehow miner must be notified at	Funeral	1701 Eutaw M. Apt. 116  11. Marital Status  12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of Hispania	c Origin? (Specif		14. Race - Americ	an Indian.
1 9	after or iter	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		Vas Decedent of Hispanio Yes, specify Cuban, Mex		ćan, etc.)	Black, White,	
(% 5.) 5-0036	ours a	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:		Yes 2 No Spe	ocity:		Specify: Blo	ick
2 ·2	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23a or 28a-f show int, the Medical Evardiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occupation kind of work done during : DO NOT use retired)	most of working	16b.	Kind of Business/Inc	dustry
2121	filed withir Hygiene. other then	duic	Elementary/Secondary (0-12) College (1-4or 5+)	1.3	e maker		1	machi	p.
		Be C	17. Father's Name (First, Middle, Last)			Nother's Name (F	irst, Middle, Maide	on Sumame)	(C)
/lar	uld be Vental irked c	ToB	Marchester Glass		Su	isie J	Hams		
<i>†a.</i> Maryland	d 2 should th and Mer ?7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Nu	umber or Rural F	Route Number, City	or Town, State, Zip	Code)
A-	s 1 end f Health item 27 other tr		I helma Averett (niece)	1535 Place of Dispos	J. Fultor	1 Ave,	Baltim	see MD	21217
<b>₹</b>	8° = 5		1 S Burial 2 □ Cremation 3 □ Removal from State	cemetery, crem	natory or other place)	od/	182	Location - City or To	
$V \notin \mathcal{S}$	보투발금 .		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Rbutu				Himore	MD
Ba	Deperm Deperm Impo		Vaucho C. Greens	2	Name and Address of Faughn C. Gure	ene Fu	neral Svo		21229
			23a. Part1. Enter the disease, or complications that caused the desshock, or heart failure. List only one cause on each line.	ath. Do not ento	er the mode of dying, such	h as cardiac or r		DEE, MID	Approximate Interval Between
	Physician		Immediate Cause (Final	n 100	arbil		avet,	O'I	Onset and Death
	/Medical		resulting in death)  Due to (or as a conse	equence of):	W 0/ n		1001	W.	
	Examiner	_	Sequentially list conditions, b. Result	a Tor	y Fai	IVYC			
,2	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence or):					
No	be executed sicien and burial-transit	Examiner	that initiated events c	equence of);		-			
1760	ate be nysicie he bur	Ical	d						
89	The law requires that the death certificate site has been signed by the attending physbage 2 should be detached for use as the	Med	IF FEMALE:						
Вох	ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth 2 Fe	tal déath 3 □	Ectopic pregnancy			23d. Date of delive Month	ry Day Year
	the a	Physician/Med	1 Yes 2 No 4 Pregnant at time of 9 Unknown	death 5□	Other (specify)			Worth	buy rear
P.0	uires that the de signed by the a id be detached f	/ Ph	Part II. Other significant conditions contributing to death but not re	sulting in the ur	iderlying cause given in P	art I.	23e. Did tobacco	use contribute to th	e cause of death?
ds	quires n sign uld be	d by	Hypertension				1 🗆 Yes	2□No 3□Prob	ably 4 @Unknown
Ö	s been s s should	olete	Handlinglemy				24a. Was an	24b. Were auto	osy findings available inpletion of cause of
Division of Vital Records,	sician: The law certificete has t irector, page 2 s	Completed	7/				autopsy performed2 1 ☐ Yes 2 Ø N	death?	
ital	sian: artifice ctor. I	Bec	25. Was case referred to medical examineer?		26. P	Place of Death (C			20.00
of ∨	Physician: this certific ral director.	ို	1  Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient				6 ☐Other (Specify	)
n C	ling P	inol.	27. Manner of Death 1 ☑ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		I. Describe how inj	ury occurred	
isi	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At	home farm stru	M 1 Yes 2		Location (Street	and Number or Rura	I Route Number
Ω̈́	after after Dire	Certification:	4 Homicide determined building, etc. (Spec	ify)	ot, factory, office		City or Town, Sta	te)	Thouse realities,
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	dlcal	29a. Certifier 17 Certifying Physician: To the best of my kr	nowledge, death	occurred at the time, date	e and place, and	due to the cause(	s) and manner as st	ated.
	the H in 24 the F nplete	Ψ.	one) and manner stated.						
	To To	Σ	29b. Signature and title of certifier		zec. License numb	per ,	29d. D	ate signed (Month, i	Jay, Year)
		1	/N	)	028236	2	AU	gust	5,2006
	1		30. Name and advanced erson who completed cause of death (Ite	700 L	Scian D	no l	Bald	mns	1220
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	29c. License numb  0.28.23 (	NO P	NAIL	11/10	
	Registr	ar	AUG 1 7 2006	S. AM	ente				

State of Maryland / Department of Health and Mental Hygiene. Amend #26 PerPhy G858 8/17/06 JH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician ÄÜĞUST 14, 2006 4:00 P M DRUCILLA GARRETT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A 722 E. 35TH STREET | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/25/1959 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛭 F 47 Yrs. MD Director 213-76-4821 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at 1 ¥ Yes 2 □ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1518 NORTH PORT STREET 21213 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Menta! Hygiene. int: If Itam 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) NURSES AIDE HEALTHCARE or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DARDEN WOOTEN FOREMAN ZEBEDIE JANNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 VAN YERRELL COURT - WOODLAWN, MD 21207 ADDIE SMITH / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. KINGS MEMORIAL PARK CEM 8/16/2006 BALTIMORE, MD 5 Other (Specify) Funeral Service Loense 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 smat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Concer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day signed by the atte d be detached for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed' 2 ne Hoap…... in 24 hours after deam. the Funeral Director: After this centilican '''...≺ in by the funeral director, p' 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Wither (Specify) Daughter's Residence 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely fi 29b. Signature title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2411 W Belvedere Ave. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			State of Maryland / Dept. State of Maryland / Dept. State Amend item#5, perINF, G858, 8/23/06 TT Compared to the state of Maryland / Dept. State of	partment of Health and Mertificate of Death	lental Hygie	7 11116	25990
	Physici		Decedent's Name (First, Middle, Last)	GOLDSTEIN	2. Date of Death Month	Day Year 14, 2006	3. Time of Death 9:43 P M
-	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	n
	Funeval	۳	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	LAUREL  v) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	PRINCE GE	ORGES
	Funeral Director		214- <del>20-1913</del> 1 M 2 T F 93 Yrs.	Months Days Hours Min.	05/25/19	13	MD
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary Fehica	to	MD PRINCE GEORGES LAU	IREL			1 X Yes 2 □ No
	ith the	Olrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	
	eath w	Funeral Director	507 GREEN HILL AVENUE  11. Marital Status 12. Was Decedent Ever in U.S. 13	20707	acity Van as No	14 Page 4=0	USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or Items 23e or 28e-f show warp injury or other traumatic event, the Medical Examinant to notified at ODGe.	Š	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto     □ Yes 2	Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0	72 ho	eted	(Specify only highest grade completed) (Given	edent's Usual Occupation re kind of work done during most of work	ing 16b	o. Kind of Business/I	ndustry
21215-0036	within lene. then	Completed		ICE MANAGER	P	HOTO FINI	SHING
pu	a! Hyg	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	den Sumame)	
Z	Mould to	2	ABRAHAM BLC				KOTZEN
, Maryland	and 2 st ealth and Th 27 is n		ADRIENNE FISHER / DAUGHTER 991	ling Address (Street and Number or Rura 2 BLUEGRASS ROAD -			ip Code)
Baltimore,	ages 1 or of H or oth		Manual 2 Clamation 3 Hamovarion State   DETI Et	position (Name of ematory or other place)  MEMORIAL PARK 8/16		DANDALL CT	
뜵	artmer ortant injury					RANDALLST	
m	Dep imp		Michael Bruger	8900 REISTERSTOWN	L LEVINSO ROAD - PI		
I			23a. Part 1. Enter the disease, or complications that Cadsed the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
ű	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  PNEUMON I	A			1 MONTH
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Division of Vital Records, I	law requires that the decase been signed by the a 2 should be detached for		Part II. Dther significant conditions contributing to death but not resulting in the ADVANCED AGE	underlying cause given in Part I.		co use contribute to	V
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ta E	hysician: The law his certificete has b I director, page 2 s	a)	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2 💢		2 No
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o uc	ding Ph h. After th funeral		27. Manner of Death  1 \( \tilde{\text{D}} \) Naturat \( 5 \) Pending \( 28a. \) Date of Injury \( \text{(Month, Day Year)} \) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe how in	njury occurred	
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ā	tal or A	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, St	tate)	
	To the Hospital or within 24 hours after To the Funcei Dir completely filled in	edical	29a. Certifier (Crieck only one)  1	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th To th comp	M	29b. Signature and fittle of centrier	29c. License number	29d.	Date signed (Month,	Day, Year)
}			· Marriagnia	D13671	А	UGUST 15,	2006
	8		30. Name and address of lerson who completed cause 23a) (Type B.G. MANESJWALA, M.D. 14201 LAUREL	, Print) . PARK DRIVE – LAUR	EL, MD 20	707	
0	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature				
	Registr	ar	AUG 1 7 2006 July Dr. Ja	sele)			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUGUST 14, 2006 GILLIS 10:45 AM G. LILLIAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE OWINGS MILLS 4730 ATRIUM COURT #610 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. Director 212-03-9017 09/01/1916 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-" any injury or other traumatic event. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits BALTIMORE MD OWINGS MILLS 1 ☐ Yes 2 X No Completed by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT #610 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 No Specify. Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** LEGAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GOL DMAN RUDMAN PHILIP SARA 2 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD R. GILLIS / SON 10696 QUARTERSTAFF ROAD - COLUMBIA, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MEN 4 ☐Donation 5 ☐ Other (Specify) 08/16/2006 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or loant failure. Ust only one cause on each line. Immediate Cause (Final **Physician** SEPTICEMIA 4 WEDGS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Duodenits Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an autopsy performed?
1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 | ER/Outpatient 3 | DOA PIS 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTIMORE MD 21208 PARIC HEIGHTS AVENUE 7220 Deborah I Pierce DO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 00 10 AM 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 01/01/1927 Birthplace (State or Foreign Country BELARUS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 79 214-94-6990 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No BALTIMORE BALTIMORE MD Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21208 USA 9226 JAMES HOWARD LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene Important: If Item 27 is marked other than "natural; or Item any Injury or other traumatic event, the Medical Exemina-Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER TAXI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GORELIK SARA SIMCHA **GELFAND** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9226 JAMES HOWARD LANE - BALTIMORE, MD 21208 FAINA GORELIK / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 08/15/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Unknown 1 Tyes 2 No 3 Probably certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient ٩ 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after deatr 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 ho To the Funs completely fi (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2206 no completed cause of death (Item 23a) (Type, Print) Kandallstown MD Dr. Lawalterton 5401

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Registrar

31. Date filed (Month, Day, Year)

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	/Medi Examir			street and number)		13,	40	Location of D	Death	-	Ic. County of Dea	
	Funeral Director		5. Social Security Number 6. Second 19 Constitution 6. Second 19 Constitution	7. Age (In yrs.  5 +	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min. (Month	Birth Day, Yea		rthplace (State or Foreign ountry) Mary land
	h the Maryland r 28a-f ahow	irector	10a. State 10b. County  HD N  10e. Street and Number		y, Town or Lo					10g. (	Citizen of What C	10d. Inside City Limits 1 X Yes 2 □ No country?
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Baltimore,	permit. Pages Department of Important: If I eny injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Tom State	emetery, crem	Cen	nete.	cy   8	3-18-06 2431 E.	30	utimor	
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	A		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	2 Pa	LACE	BACT	7/10/	ef, MO	21202
П	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 2006	37 Registrar's Signa	ure	WE !			* /			

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		Registrar	-	Ce	rtificate c	of Death		Reg. No	UU	40794
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Page Page nent o		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	ARI	outu		8/	18/2006			MD
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OT VITA Physician: this certific ral director.	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:			0.1	Death Check only			
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DIVISION OT VITAL HECONDS,  To the Hospital or Attanding Physician: The law requires to within 24 hours after death.  To the Funeral Director: After this certificate has been signed, mighted by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom	e, farm, str	M 1	Yes 2 No			ber or Rur	al Route Number,
DIVISIC  To the Hospital or Attanc within 24 hours after deatt To the Funeral Director: cumpletely filled in by the i	Cert		building, etc. (Specify)					wn, State)		
ns Hos n 24 ho he Fun pietely i	Medical	(Check only 2 Medical Examone)	sician: To the best of my knowle mer: On the basis of examination and manner stated.	n and/or in	occurred at the restigation, in m	e time, date and pl ny opinion, death o	lace, and due to the occurred at the time,	date and place,	anner as s , and due t	stated. to the cause(s)
Tot Tot	Σ	29b. Signature and title of certifier	7· D			ense number	7	29d. Date signe		
le.		30. Name and address of person who c				00	0		^-	7.11
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	9		DRIVE	Russia	الما	1100	~1136
Registra DHMH 17 Rev 1/20		AUG 1 7 2	006	J. 1	bark			<del>, ,</del>		
			-	ORIGIN	JAL					

06-06007 Jethro Hayes

# Please Type or Print in Black Indelible Ink

ellio Hayes		I- For State Registrar		nent of Health a icate of Death	nu ivientai r		g. No. O O F	16 2500
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)  Jethro Hay	res			2. Date of Death Month August 13,	in the	3. Time of Death
		4a Facility Name (if not institution, give street and not 1517 North Appleton Street	ımber)	4b. City, Town, Baltimpre	or Location of Deat		4c. County of Dear	<b>L</b>
Funeral		5. Social Security Number 6 Sex	7 Age (In yrs. last b	oirthday) If Under 1 Y	ear If Under 24Hr			irthplace (State or
Director	-	245-66-3766 1 MM 2 F	64	Yrs. Months D	ays Hours Mi	1/6/19	942 c	ountryMarietta,
w any	ŀ	10a. State 10b. County		wn or Location				10d Inside City Limits
ne Maryland or 28a-f show any fied at once.	Director	MD  10e. Street and Number	Balti	more 10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	10	g Citizen of What Co	1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.		1517 North Appleton St		21217			Jnited Sta	
15-0036 filed within 72 hours after death with the Maryland I Hygiene et other than "natural", or items 23a or 28a-f She i, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed F	2 X No		oan, Mexican, Puert		14 Race - Ame White, etc.  Specify: Bla	rican Indian, Black,
ours after	최	3 Widowed 4 Divorced If Yes, Give Ye or Dates:  15. Decedent's Education (Specify only highest grades)		a. Decedent's Usual Occu	pation (Give kind of		Specify: 16b. Kind of Business	
5-0036 led within 72 hours Hygiene other than "natur	Completed	Elementary/Secondary (0-12) College (	1-4 or 5+)	during most of working		tired)	Construct	ion
21215-0036 ould be filed within 7 dental Hygiene s marked other than it event, the Medica	Com	17 Father's Name (First, Middle, Last)  Justin Hayes				ne (First, Middle, M Dixon	aiden Surname)	
<b>2</b> 9 8 8 <b>5</b>	To Be	19a. Informant's Name/Relationship (Type, Print )		19b. Mailing Address (St	reet and Number or	Rural Route Numb	· · · · · · · · · · · · · · · · · · ·	
re, MD 2 1 and 2 shoul f Health and M If item 27 is m er traumatic	-	Chris Hall ( nephew )  20a Method of Disposition	20b. Place	10487 Markby e of Disposition (Name of		White Pla	20c Location - City o	
Baltimore, MD 21 bemit Pages I and 2 should Department of Health and Me Important: If item 27 is ma nijury or other traumatic ev		1 XBurial 2 Cremation 3 Removal f 4 Donation 5 Other Specify:		natory or other place) igator Cemet	-		Marietta,	
Baltimore permit. Pages 1 Department of H Important: If in		21. Signature of Funeral Service Licensee					oln Funera rentwood,	
Physician /Medical		23a. Part I. Enter the disease for complications that of failure. List only one cause on each line.			Approximate Interval 8etween Onset and			
Examiner		, , , , , , , , , , , , , , , , , , , ,	ive AtherDsclerD a consequence of):	tic Cardiovascular [	Disease			Death
	Jer		a consequence of):					
Sit B P	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as	a consequence of):					
0, be executed sician and ourial - transit	Medical E	d UNPENDED AMENDED						
3760, ificate be ex ig physician s the burial		23b. Was decedent pregnant in the	outcome of pregnant	, <u> </u>	3 Ectopic pregr	nancv	23d Date of delive	ry Day Year
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/	past 12 months?	nant at time of death	5 Other (Specify)				Day You
P.O. B es that the de gned by the e detached f	by Ph	Part II. Other significant conditions contributing	o death but not result	ting in the underlying caus	e given in Part I.		pacco use contribute to	F 3
ords, P.C. w requires that should be deta	eted t					24a Wasa	n 24b. Were a	utopsy findings available
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  "I Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	-				autops perform 1 <b>Y</b> Yes 2	ned? death?	
ital Rec sician: The s certificate irector, page	B	25. Was case referred to medical examiner? Hospital:	Inpatient 2 ER	26.Pla /Outpatient 3 DOA	Other Nurs	,	Residence 6 V Othe	ar Scene
of Viring Physical After this funeral direction	n: To	1 Motorel (Mont			njury at Work?		ow injury occurred	57. 000110
ivisior I or Attend after death. Director:	Certification:	2 Accident Investigation 28e Pla	ce of Injury - At home	, farm, street, factory, office	Yes 2 No	28f, Location (Si	treet and Number or R	lural Route <b>N</b> umber, City
DIVIS Hospital or At 24 hours after d Funeral Direct tely filled in by		4 Homicide determined (Specify				or Town, St		
To the Hospita within 24 hours To the Funeral completely fille	Medical	Check only one) Medical Examiner: On the basis and manner	of examination and/o					
F % F 5	M	29b. Signature and title of certifier	$\bigcirc$		ense number		29d. Date signed (MA) August 14, 2006	
		30. Name and address of person who completed cau		a)				-
14	ate	Laron Locke MD. Assistant Medic  31. Date filed (Month, Pay, Year) 2006 32. F	egistrar's Signature	111 Penn Street, Ba	Itimore, MD 21	201		
Regist		31. Date filed (Month, Day, Year) 7 2006 32. F	Holica D	15/30/50				

			1 - For State Registrar	State of	Marylar		rtment of H	lealth and M Death	lental Hygie	//	006	25995
	Physici /Medi		Donald  D	, Last) FRANK	LIN		HIEGGBY		2. Date of Death Month AUGUST	Day 15,	Year 2006	3. Time of Death 12:35PM
	Examir	ner	4a. Facility Name (If not institution, UPPER CHESAP)	EAKE HOSE	KE HOSPITAL			Location of Death			tc. County of Death HARFORD	
	Funeral Director		5. Social Security Number 212-34-5489  Usual Residence of Decedent	6. Sex 7. 1 ☑ M 2 ☐ F		last birthday) 59 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 7 – 24 – 1 9	937	9. Birthplace (State or Foreign Country) MARYLAND	
	death with the Maryland ime 23a or 28a-f show If Invet be notified at	ctor	10a. State 10b. County	RFORD	10c. Ci	ty, Town or Lo	JOPPA				10	od. Inside City Limits
	ath with the 23e or 28	rai Director	10e. Street and Number  8 GUNPOWDER	DRIVE			10f. Zip Code 210	85	10g.		What Count	
-0036	or Ite	by Funeral	11. Marital Status  1 Never Married 2X Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ſXNo	l ii	Vas Decedent of Hi Yes, specify Cuba □ Yes 2⊠ No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		ce - America ick, White, e fy: W	
35.	within 72 hours ene. then "naturel" the Medical Ext	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1 2	s Education t grade completed) College (1-4	or 5+)	(Give	O NOT use retired	during most of workii	ng		Business/Ind	ŕ
land 2	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other then other traumatic event, the Ms	To Be Co	17. Father's Name (First, Middle, L WILLIAM	Last)		HIEGG			(First, Middle, Mai			
, Maryl	s 1 and 2 shown of Health and Is item 27 ie ma		19a. Informant's Name/Relationsh MARY E. HIEGO			8 GU	NPOWDER	and Number or Rura DRIVE	JOPPA,	ty or Town	210	85
5 b (	Page ent o nt: If ry or		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.  21. Signature of Funeral Service L	ecify)	ate C	emetery, crem ETRO C	REMATOR	<sup>e)</sup> Y 8-19	9-06 C	ATON		wn, State LE, MD ERAL HOME
S	permit. Depertm Importa any inju		23a. Part1. Enter the disease, or shock, or heart failure. List of	-UL	sed the deat	12	11 CHES	ACO AVEN	NUE RO	ROSEDALE, MD 212		
•	Physician /Medical Examiner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. De to (or	espil	ration uence of):	Par	lure	/			Interval Between Onset and Death
9360	icate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (or d.	as a consequence of as a consequence of	uence of):	ctive V	ulmona	y Disi	rusc	is	Jeens
0. Box 6	that the death certifics ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Feta t at time of d	Ideath 3	Ectopic pregnancy Other (specify)				ate of deliver onth	y Day Year
M M	sign 1 be	by	Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the un	derlying cause give	on in Part I.	23e. Did tobacc	co use con		cause of death?
I Reco	iiclen: The law requ certificate has been rector, page 2 shouk	Completed	fulmonar	, Hype	, ters	100			24a. Was an autopsy performed	ą	prior to com death?	sy findings available pletion of cause of
on of Vite	ding Phys	tion; To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending investig.			ER/Outpatient 28b. Time of Injury	28c. Injury Work	4   Nuising Hon	Check only one ne 5  Residence 8d. Describe how in			
Division	el or Attends after death	Certification:	3 Suicide 6 Could not determine	ot be 28e. Place of	Injury - AI h etc. <i>(Specif</i>	ome, farm, stre	et, factory, office		28f. Location (Street City or Town, St	and Numb	per or Rural	Route Number,
王	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (	(Check only 2   Medical E	Physician: To the be examined: On the basis and manner	s of examina	wledge, death tion and/or inv	estigation, in my op	inion, death occurre	d at the time, date	and place,	and due to t	he cause(s)
	5 T W 5 0		29b. Signature and title of cayiffiar 36) Name and lidress of person v	who completed cause of	D, FA	2 Sa) (Type, F	29c. License	34027	¬ i//		d (Month, D. 4 16	21040
	Sta	te	31. Date filed (Month, Day, Year)	5TL DO 1	308 istrar's Signa	Bus;	ris Cer	ske llay	. Edger	wood	MO	21040
3	Registr	ar	Alig 1 '	7 2006	Sent And I	D. A.	osili					

			1 - State Registrar	State of Maryl		artment ertificate			nd Me	-	giene Reg. No	200	16 25997	
	Physici		Decedent's Name (First, Middle, Last)     W17	ARREN LEV	TNE HO	OK	-			2. Date of De Month	ath Day	y Yea		
100	/Medio Examin		4a. Facility Name (If not institution, give street CARROLL HOSPITA	eet and number) L CENTER		4b. City, 1 WES	STM]	Location of	Death R		4c.	2006 County of D	OLL	
	Funeral Director		5. Social Security Number  217-50-1479  Usual Residence of Decedent	7. Age (In	yrs. last birthday	Months	1 Year Days	If Under 24 Hours	Min.		ate of Birth 9. Birthplace (Standorth, Day, Year) 9. Birthplace (Standorth, Day, Year			
	the Maryland 28e-f ehow	Director	10a. State 10b. County MD CARROLI  10e. Street and Number		City, Town or I						10a Cit	10d. Inside City Limits 1 □ Yes 2X No		
036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene. It Health and Mental Hygiene. Items 77 is marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, the Macical Examinar must be codified at	by Funeral Dir	1032 GAHLE RD.	12. Was Decedent Ever in U.S. Armed Forces? In Yes 2 ⊠No			21157  Was Decedent of Hispanic Origin? (Specify Yes or I Yes, specify Cuban, Mexican, Puerto Rican, etc.)  U Yes 2X No Specify:					10g. Citizen of What Country?  USA  No- 14. Race - American Indian, Black, White, etc.  Specify: WHITE		
Maryland 21215-0036	filed within 72 hor Hygiene. other than "natura ent, the Medical E	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0-12)		(Giv life.	edent's Usual e kind of work DO NOT use NTENAI	k done di e retired)	uring most o			16b. Kind of Business/Industry  APARTMENTS		,	
yland	should be fill ind Mental Hy smarked oth umatic even	To Be		STERLING				EVA	EL	(First, Middle, IZABE'	TH S	SHIPL		
	t and 2 sh Health and tem 27 is m other traum		19a. Informant's Name/Relationship (Type, LINDA J. HOOK – 20a. Method of Disposition	WIFE	103	2 GAH	LE E	RD.,		Route Numbe	TER	, MD		
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item eny injury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)								SMA FUN	DD, MD HOME		
	whe person of the private of the pri	dicai Examiner	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	cause on each line.	eath. Do not en	nter the mode	of dying	, such as ca	ardiac or				Approximate Interval Between Onset and Death	
.O. Box 6	ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pred □ Other (spec					2	23d. Date of o	delivery Day Year	
ords, P.	w requires that the de been signed by the a should be deteched f	ል	Part II. Other significant conditions contril Hyperstensor Vicerstensor			underlying ca	use giver	n in Part I.				_	to the cause of death?  Probably 4 □Unknown	
		Completed	<u> </u>	Cal Ky					_	1 ☐ Yes	sy med? 2 \(\begin{align*} \text{No}	prior to	autopsy findings available o completion of cause of ? es 2⊟No	
Division of Vital Records,	בי יובי	ation; To Be	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation	pital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time of Injury		Other c. Injury : Work?	4 ☐ Nursi	ing Home	Check only or e 5 ☐ Resid ad. Describe h	ence 6		pecify)	
DIVIE	urs after death	Certification;	4   Homicide	28e. Place of Injury - A building, etc. (Spe	ecify)					City or Tow	n, State)		Rural Route Number,	
	within 24 hours after To the Funerel Dire completely filled in b	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physici 2 ☐ Medical Examiner 29b. Signature and title of certifier	en: To the best of my: On the basis of examand manner stated.	knowledge, dea ination and/or i	estigation, i	t the time n my opi	nion, death o	occurred	d at the time, d	late and	place, and d	ue to the cause(s)	
}	10		30. Name and address of person who comp						35				nih, Day, Year)  CG  21157	
	Star Registra	e	31. Date filed (Month, Day, Year) AUG 1 7 2006	32 Jegistrar's Si		91	7-1	へのと	L.	ot (	PM		21157	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** DYCE 2006 5:35 /Medical 4a. Facility Name (If not institution, give stleet and number) 4c. County of Death 4b. City-Town, or Location of Death Examiner CENTER LOSSMITAL BALTIMONE BATTURE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Yrs. Director 6 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other then "nature!", or Items 23s or 28s-f show other traumatic event, the Micdical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa If Yes, specify Cuban, N panic Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince George's Hospital Elementary/Secondary (0-12) College (1-4or 5+) Technician 4ears enter Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental I Nobors Bessie Williams ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7602 Amore Cr Gonya Henson bughter caknoville mo 20a. Method of Disposition

1△Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ŏ permit. Page Depertment of Importent: if eny injury or page. 8 2006 Ba 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility vaugnn Greene Juneral Rd Randallsteun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. ENDO ME Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Minknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 2 No 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funeral d Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. i Director: A 1 | Yes 2 | No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 29a. Certifier TV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of come 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) Routille

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

ORIGINAL

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death reiser **Physician** 2006 /Medical 4c. County of Death Name (If not institution, give sti eet and number 4b. City. Town, or Location of Death Examiner Himore 6. Sex If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 10 M 20 F Days Min Yrs Director 182 343137 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Pres 2 No Completed by Funeral Director restministe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 USA . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Ho o lf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) Printer 79 rint 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kr-eiser USCRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21157 Donnia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Deremation 3 ☐Removal from State letro 4 □ Donation 5 □ Other (Specify) -21-06 xemator 21. Signature of Fameral Sa 22. Name and Address of Vacility mid Valley Dr. Jussup, PA 11AM 1232 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in peath) **Physician** Lovarive Squamous Cell Carcinoma, Invasive /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the hurial transit Hospital or Attending Physicien: The law requires that the death certificate be executed MENINGITIS Due to (or as a consequence of) Emboli PULMONON Physician/Medicai BILATERAL IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) ed by the a P.O. 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2□ No 25 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation To the nuce after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the state of 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00573 30. Name and dress of person who completed cause of death (ftem 23a) (Type, Print) SVICE SON BAILBONE, MD JIM S. WOLF 16 Snoth

Registrar

State

31. Date filed (Month, Day, Year)

AUG 1

7 2006

32. Registrar's Signature

			1 - State Registrar Amend #20b Per	State of Marylar FH C858 8/17/06					nd Me	-	giene Reg. No.	0.5	26000
	Physicia	an	1. Decedent's Name (First, Middle, Last)	,					2.	Date of De	ath Day	Year	3. Time of Death
Zin. ;	/Medic	al	FLOTA FT.  4a. Facility Name (If not institution, give s	sophiek		4b. City, T	our or l	continu of	Doath	up no	1/4	ty of Death	2000 A M
Ti.	Examin	er	4a. Pacinty Name in not institution, gives	Hamtal		1	1 4	(XI)W			4c. Court	al tin	
	Funeral		5. Social Security Number 6. Sex			If Under 1	1 Year Days	If Under 2	4 Hrs. 8.	Date of Birt	th v Year)		lace (State or Foreign
	Director			M 2√ F 9	7 Yrs.	WOTHIS	Days	riours		05/23,	71909	000	MD
	land ow	}	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	a-f eh	tor	MD N/A		BALT	IMORE							1 X Yes 2 □ No
	72 hours after death with the Maryland natural; or items 23a or 28a-f ehow disal Examinar mant be notified at	Director	10e. Street and Number	AVENUE #706		10f. Zip (		1015	-		10g. Citizen of	What Cour	•
	eath w		7111 PARK HEIGHTS	2. Was Decedent Ever in L	10 12 1	Was Dagode		21215	in? /Specif	y Ves or No	14 B	ice - Americ	USA Pan Indian
ထ	after d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No		Was Decede			Puerto Rio	an, etc.)		ack, White,	
903	urai', c	d by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1□ Yes 2	M No	Specify:			Spec	ify:	MULLE
15-(	n 72 hours "natural",	lete	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual kind of work DO NOT use	k done du		of working		16b. Kind of	Business/In-	dustry
212	f within jiene. r then "	Completed	Elementary/Secondary (0,12)	College (1-4or 5+)		MAKER	3 701,7007				OWN HO	ME	
pu	be filed Ital Hygi Id other	BeC	17. Father's Name (First, Middle, Last)				1			First, Middle,	, Maiden Suma	ıme)	0011511
yla	should be and Mental marked o	၉	CHARLES		SNYD		10:1		ECCA				COHEN
Maryland 21215-0036	12 c c c c c c c c c c c c c c c c c c c		19a. Informant's Name/Relationship (Ty) ALLAN KROOPNICK /								er, City or Tow MORE,M		
	es 1 and of Health f item 27 r other ti		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	e of		/16/200		20c. Location		
imo	Pages ment of ant: If it		1 🕅 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		AREÍ Z						ROSE	DALE,	MD
Baltimore,	permit. Pag Depertment Important: I eny in ury o		21. Signature of Funeral Service License	Cuttle							SON & B PIKESVI		INC. MD 21208
	ž.		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea e cause on each line.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	suptillh	ija.								Onset and Death
	/Medical Examiner		1	Due to (or as a conse	quence of):	17/ 10-	_	4	, ,				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):	Ubst	rnc	CION				-	
	acuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
8760,	death certificate be executed e ettending physicien and id for use as the burial-transit		resulting in death) cast	Due to (or as a conse	quence of):								
687	ficate phys	Physician/Medical	~ d										
Box (	eath certific ettending p I for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		7C+++-i		-			23d. D	ate of delive	ery
	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pre □ Other (spe		_			٨	onth	Day Year
P.0	that the de ned by the deteched		9 ☐ Unknowh  Part II. Other significant conditions con		sulting in the u	Inderhina ca	usa anyan	in Dart I		23a Did t	obacco usa co	ntribute to t	he cause of death?
of Vital Records,	8 5 8	d by	, a., o., o.,	thousand to doubt out not to	30.mig #1 (110 G	inderlying ca	iuso givoi	rair aiti.		1 🗆			pabiy 4 □Unknown
CO	w requir s been si should	lete								24a. Was	an 24b	. Were auto	opsy findings available
Re	The lav sete has page 2	Completed					-			auto perfo 1 Yes	psy ormed? 2 No	prior to co death? 1  Yes	impletion of cause of 2□ No
/ita	Physician: 1 this certificeral director, p	Be	25. Was case referred to medical examiner?				1 -		of Death (	Check only			
of \	Phys this ral dii	. To	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 2	ER/Outpatier			4 LI NUI			dence 6 C		(y)
lon	Attending I r death. ector: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M	3c, Injury a Work? 1 □ Ye	at es 2∐N		u. Describe	now injury occ	unea	
Division	or Attand efter death Director: A in by the fi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory,	, office		28	f. Location ( City or To		nber or Rura	al Route Number,
۵	pitei or urs efte eral Dire												
	To the Hospitel or Att: within 24 hours efter de To the Funeral Direct completely filled in by ti	edical	29a. Certifier 1 Certifying Physics (Check only 2 Medical Examisone)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	th occurred a evestigation,	at the time in my opi	e, date and inion, deat	d place, and h occurred	d due to the at the time,	cause(s) and a date and place	manner as s e, and due t	stated. o the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c.	. License	number			29d. Date sign	ned (Month,	Day, Year)
	-		Alice 1-15	1			114	+39	74		Aufner	- 14	2006
	20		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)			+ 7		Aufna Journ		,
	Sta	ete.	31. Date filed (Month, Day, Year)	32 Registrar's Sign	hues?	1 /1	01017	t2/	Rai	1345	town.	mary	2nd
	Registi		AHG 1 7 2006	100	1 Son	and I	,					/	